Maternal and Child Health Services
Title V Block Grant

State Narrative for Wisconsin

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

ASSURANCES & CERTIFICATIONS Attached
An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2008/ The 2007 Wisconsin Title V MCH Services Block Grant Application is found on the DHFS website at http://dhfs.wisconsin.gov/DPH_BFCH/BlockGrant/. The public and interested parties in MCH and CYSHCN related services are encouraged to provide input via the website at http://dhfs.wisconsin.gov/DPH_BFCH/PublicInput.asp. The web public input section relates to the top 10 priority needs that emerged from the needs assessment. Four questions were asked:

- What are your comments or suggestions regarding the newly defined "Top 10" priority needs;
- Do you have suggestions for specific performance measures to address these needs? (e.g. Percent of women who use tobacco during pregnancy);
- Other comments; and
- List of options which best describe you.

From July 2006 through submission of the grant in July 2007, we provided the 2007 block grant application as a template and asked for public input through the DHFS website, from our partners around the state including all local health agencies, the five regional public health offices, MCH statewide projects, and the Regional Centers for CYSHCN; at advisory meetings (e.g. MCH Advisory, WAPC); community meetings (e.g. Black Health Coalition and Great Lakes Intertribal Council); and conferences and meetings involving families of CYSHCN (e.g. Circles of Life Conference). The information was gathered by state MCH program staff and shared at our staff meetings. The information from all the MCH partners and meetings along with the 20 comments from the DHFS webpage were incorporated into the writing of our 2008 grant application or as a point of reference for future planning as well as an evaluation of how we are doing communicating and meeting our state priorities and performance measures. The input received validated the need for the defined priorities and individuals offered suggestions on topics such as: oral health, mental health, contraceptive services, and health disparities. //2008//

/2009/ The "call for submissions" distribution plan used this year is the same as last year. A total of 21 comments were received through the DHFS website. The input received again validated the need for the aforementioned priorities. In addition, the following areas of need were emphasized: infant mental health awareness and provider training; dental health access and affordability issues (especially in rural areas); adequate and appropriate nutrition and obesity and

overweight, highlighting the rising problems with food insecurity; and alcohol use among pregnant women. Advocates and Benefits Counseling for Health (ABC for Health) provided input emphasizing the need for a statewide infrastructure to assist families with children and youth with special health care needs to connect to both health care coverage and medical services. Two additional venues were used to gather public input this past year, the statewide Reproductive Health and Family Planning trainings and the MCH Regional Forums that were held in each of the five health regions in the state. //2009//

/2010/ Public input was solicited through the DHS website. A total of 15 comments were received. Areas of emphasis include: dental health access, mental health, prenatal care, disparities in birth outcomes, childhood obesity, and an overarching focus emphasizing the importance of partnerships.

These topics were discussed with the diverse membership of the MCH Advisory Committee. In 2008, the MCH ten priorities, corresponding performance measures and current status updates were presented and discussed with committee members. Committee recommendations were integrated into program activities for the year. The MCH Advisory Committee has continued to provide assistance with the Joint Integration of Physical Health, Mental Health, and Substance Use and Addiction Initiative at the committee's quarterly meetings. The DHS Joint Integration Internal Work Group meets with the MCH Co-Chairs to further advance the committee's collective membership integration efforts statewide.

Input related to MCH data collection and program evaluation was obtained through 5 regional forums with LHDs and tribal programs. Data sheets were developed and template objectives reviewed and revised accordingly.

Another venue for the MCH Program to receive public input is taking place through the Healthy Birth Outcomes Initiative to eliminate racial and ethnic disparities in birth outcomes. A Statewide Advisory Committee meets 3 times per year to hear updates on state and local efforts and to offer suggestions and recommendations. Meetings are rotated in communities with highest rates of African American infant mortality (Beloit, Kenosha, Milwaukee and Racine) and in Madison which has dramatically reduced its African American infant mortality rate. Approximately 50-100 interested people attend these meetings. A mailing list for written updates and new web postings reaches nearly 200 individuals. A written report of recommendations to DHS is being drafted and reviewed for publication later this summer. Four workgroups of more than 60 individuals have been meeting over the past 2 years to develop these recommendations. See www.dhs.wisconsin.gov/healthybirths for more information.

In addition, we have held annual town hall meetings since 2006 to discuss the DHS Framework for Action that outlines goals, objectives, and activities for eliminating racial and ethnic disparities in birth outcomes and have drawn over 100 members of the public to each of these meetings. Also, through the two social marketing efforts, first funded with state funds from the Minority Health Program (ABCs for Healthy Babies) and now with HRSA/MCHB funds (ABCs for Healthy Families) from the First Time Motherhood/New Parents Initiative, we are conducting focus groups of African American mothers, fathers, and grandmothers to learn first hand how maternal and child health services can better meet the needs of our clients. In addition, community residents are members of our Community Advisory Board for the grant and are being trained to administer surveys to the public. Next year we will be able to report on the findings of these surveys on knowledge, attitudes, and behavior regarding the life-course perspective for MCH services, including the effects of racism, and the importance of involving fathers in MCH care. See also Section B State Priorities. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Table 1 (see Section II. C. - Needs Assessment Summary attachment) compares Wisconsin's 2000 ten priority needs to those from 2005. Six needs are similar; 4 reflect emerging issues about mental health, medical home, overweight/at risk for overweight, and unintentional/intentional injuries. Four needs from 2000 did not align with new needs: child care, family and parenting, CYSHCN systems of care, and early prenatal care. These needs are integrated into WI's Title V programs' 2005 priorities and addressed in the new State Performance Measures (SPMs): dental services, age-appropriate social-emotional development, child maltreatment, medical home, physical exam for children, obese/overweight children, ratio of the black to white infant mortality rate, and motor vehicle teen (15-19) death rate.

Below are the two SPMs that were changed to reflect new directions for contraceptive services and dental health for 2007.

Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year

Expansion of contraceptive and related reproductive health care services highlights implementation of the Medicaid Family Planning Waiver (MFPW). An increasing volume of services to women between income levels of 185-250% of poverty is anticipated. This supports the objective in Healthiest WI 2010 to reduce to 30% unintended pregnancies among residents.

Activities related to continued promotion and outreach for the MFPW is coordinated with the Governor's 2004 Healthy Kids Initiative as it identifies a series of steps to improve child health. One step is to "Step up efforts to reduce Teen Pregnancy". WI has seen an overall decline in teen births. The MFPW is one of the most successful programs to address this issue.

Technical assistance, support, and continuing education activities for publicly supported family planning providers continue and focus training on clinic quality improvement and results from social marketing research. Increase in awareness of and access to timely contraceptive services is a priority.

/2008/ See SPM #1 for update of Family Planning Waiver activities. //2008//

Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year

DPH secured WI Partnership funds for LHDs and tribal health centers for the "Beyond Lip Service" program. Funds distributed through an application process targeted the Northern Region. Technical assistance helps maintain fluoridation of existing community water systems and increases the number considering fluoridation. The School-Based Fluoride Mouth Rinse Program provides ongoing assistance to increase numbers in elementary schools.

Oral health in the Governor's KidsFirst Initiative promotes expansion of the WI Seal-a-Smile Program, integrates preventive oral health into health care practice and increases use of dental hygienists to prevent oral disease.

Spit Tobacco Program works with DPI to serve 5th graders during the school year. A "Brewers

Day in the Park" features topical comic books.

Integrating Preventive Oral Health Measures into Healthcare Practice training is offered to federally qualified health centers (FQHC), tribal health centers, LHDs, medical education, and Head Start programs serving low income infants and toddlers. The Oral Health Consultants are responsible for prevention programs in the 5 DPH Regions and local communities including CYSHCN.

DPH promotes Oral Health Surveillance surveys to establish baseline status of 3rd graders.

Chippewa Valley and Western WI Technical Colleges serve all persons as a service learning opportunity for dental hygiene students who bill Medicaid for some services. GPR funds for CESA 11 and Marshfield Family Health Center rural dental health clinics provide preventive and clinical services to low income families.

/2008/ See SPM #2 for updated Dental Services information. //2008//

New SPMs for children with age-appropriate social and emotional development, child maltreatment, and children's medical home.

Activities for these SPMs will be in conjunction with the Wisconsin Medical Home Initiative and WISC-I Grant; the WI Infant Mental Health Initiative and the Mental Health and Social-Emotional component of the ECCS Grant; and the WI Injury Prevention Program.

/2008/ See SPM #s 3, 4, 5. //2008//

Outcome Measures - Federal and State
Table 2 (see Section II. C. - Needs Assessment Summary attachment) crosswalks the State's Priority Needs, National Performance Measures (NPMs), State Performance Measures (SPMs), and Healthiest WI 2010.

Additional Information on "Cultural Competency" and "Challenges and Barriers" can be found in the attached (see Section II. C. - Needs Assessment Summary attachment).

/2009/ Additional "challenges" include: 1) Consistent choice of priorities to be addressed by partners receiving MCH Title V dollars and 2) Ability to measure effectiveness over time, which usually takes more than one year to measure and requires our partners to continue their activities and programs for more than one year

Since submission of the previous Title V MCH Block Grant Application and Report in July 2008, there are no differences in the State's priority needs and no changes in needs assessment processes. Surveillance of disparities in birth outcomes, injury, oral health, etc. has continued to support the priorities established and the activities occurring to address the identified priorities. In preparation for the next 5 year Needs Assessment which will be submitted with the 2011 application in July 2010, the Title V Program is developing a process and workplan proposal and timeline for the activities. //2009//

/2010/ Over 100 entities receive funding through the Title V MCH Block Grant. As part of the contractual relationship with each funded partner, a report is required to be submitted at the end of the calendar year. The 2008 End of Year Report included 3 narrative questions designed to solicit input from partners regarding unmet needs and emerging issues. The three questions were:
1) Provide a description of how all of your MCH programmatic activities advance one or more of the State's MCH Priorities.
2) What MCH related priorities were identified in your most recent community needs assessment process? Which of these are you currently or planning to work on in the

upcoming year, two years, and five years?
3) Based on your experiences over the past year, what do you feel are the most important unmet needs and emerging issues impacting the health of mothers and children in your jurisdiction?

A total of 86 responses were received from a variety of partners. Analysis of responses indicate all determinants and risk factors identified in the previous needs assessment conducted in 2005 continue to be impacting the health of families, women and children. Two additional issues were not apparent in the previously identified determinants and risk factors (Alcohol use, especially among pregnant women and Economic and poverty-related impacts on health)

As the Needs Assessment continues throughout 2009 and a strategic plan is developed, the Title V Program will be looking closely at activities and strategies to address these two emerging issues. //2010//

An attachment is included in this section.

III. State Overview

A. Overview

STATE HEALTH AGENCY'S CURRENT PRIORITIES

Wisconsin's State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public was released in early 2002. All related documents are available on CD-ROM to include:

1. State Health Plan
2. State Health Plan Executive Summary
3. Wisconsin's Stakeholders Report
4. Minority Health Report
5. Implementation Plan (All Templates and Logic Models)
6. Mapping Project
7. Local Public Health Systems Partnership Database Introduction
8. Local Public Health Systems Database
9. Healthiest Wisconsin 2010 Annual Status Report 2004

The State Public Health Plan fulfills the legislative requirement to develop a state public health plan at least once every ten years as required in Wis. Stats. 250.07. Participation in implementing and monitoring progress, over the remaining five years continues to involve diverse partners including state and local government, nonprofit and private sector, and consumers. The DPH Administrator uses the State Public Health Plan as a major reference guide to determine the importance and magnitude of maternal and child health services when compared with other competing factors that impact health services delivery in Wisconsin. With finite funds, this planning is imperative.

The Healthiest Wisconsin 2010 defines "public health" and the 12 essential public health services. The document describes the five system (infrastructure) priorities and the 11 health priorities that will set the stage for public health programs. The system priorities are: 1) integrated electronic data and information systems, 2) community health improvement processes and plans, 3) coordination of state and local public health system partnerships, 4) sufficient and competent workforce, and 5) equitable, adequate, and stable financing.
Wisconsin's 11 health priorities, listed alphabetically, are:

- Access to primary and preventive health services,
- Adequate and appropriate nutrition,
- Alcohol and other substance use and addiction,
- Environmental and occupational health hazards,
- Existing, emerging and re-emerging communicable diseases,
- High-risk sexual behavior,
- Intentional and unintentional injuries and violence,
- Mental health and mental disorders,
- Overweight, obesity, and lack of physical activity,
- Social and economic factors that influence health, and
- Tobacco use and exposure.

Underlying Healthiest Wisconsin 2010 is the comprehensive view of health that we have long embraced in the MCH/CSHCN Program. This includes not only physical and mental health but also social, spiritual, and community well-being. This view of health affirms the essence of MCH, which lies not only in the prevention and reduction of morbidity, mortality, and risk but also in the fostering of the potential for children and families to become compassionate, productive, and dignified citizens.

In 2004, we prepared a navigational tool to help LHDs see the direct connection between

Healthiest Wisconsin 2010 priorities and objectives with MCH/CSHCN Program as they consider making application for Blue Cross/Blue Shield (BC/BS) resources and negotiating for performance based contracting. This tool was important because both of Wisconsin's medical schools require that BC/BS applications align with the state health plan's priorities. (A copy of the navigational tool is available upon request.)

Intense efforts to monitor progress and track accomplishments for each of Wisconsin's 11 health priorities began in 2005. The first DHFS Annual Status Report was completed this year with the purpose to improve communication between the Department and its partners related to the implementation of Healthiest Wisconsin 2010 and to describe new initiatives that are underway. Tracking the State Public Health Plan provides access to state-level data on indicators that track progress toward meeting many of the 2010 objectives. Indicators were developed to measure a given objective based on the availability of state-level data.

Finally, results from our 2005 (required) Title V needs assessment are closely linked to seven of the 11 State Public Health Plan priorities as follows: access to primary and preventive health services; high-risk sexual behavior (which includes pregnancy); intentional and unintentional injuries and violence; mental health and mental disorders; overweight, obesity, and lack of physical activity; social and economic factors that influence health; and tobacco use and exposure.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ The process for developing WI's state health plan, Healthiest WI 2020, has begun. The WI MCH Program and its statewide partners were provided an overview of the process at the March MCH Advisory Committee meeting and the Family Health Section meeting. They were invited to participate on planning committees to work on the revisions and additions to the present Healthiest WI 2010 state plan which will then become the 2020 plan. //2009//

/2010/ A Strategic Leadership Team (SLT) is providing leadership to guide the development of "Healthiest Wisconsin 2020: A Plan to Improve the Health and Safety of the Public (HW2020)." Title V staff are active members of the SLT determining statewide health and infrastructure "focus areas" representing the landscape of forces/factors influencing the health of the public. HW2020 will carry the message that the focus areas do not exist as independent "entities," rather, the plan, and its companion implementation plan, will communicate and stress, in both word and action, the co-influencing nature of the focus areas.

The Title V Program advocated for the new state health plan to reflect a life course approach. Increasingly, the life-course approach is playing an important role in understanding population health and well-being and was an important addition to the HW 2020 Plan. As such, healthy growth and development and reproductive and sexual health are included in the final list of 12 focus areas. Additional work will continue throughout 2009 including establishment of two policy priorities for each of the focus areas identified and the development of the accompanying implementation plan. //2010//

PRINCIPAL CHARACTERISTICS OF WISCONSIN

The information is adapted from the following data sources: 1) 2000 U.S. Census; 2) the State of Wisconsin, 2003-2004 Blue Book, compiled by the Wisconsin Legislative Reference Bureau, 2003; 3) the Anne E. Casey Foundation Kids Count Online Data available at: www.aecf.org/kidscount/data.htm; 4) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Infant Births and Deaths, 2003, Madison, Wisconsin, 2004; 5) Wisconsin Department of Health and Family

Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Deaths 2003, Madison, Wisconsin, 2004; 6) Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000. Madison, Wisconsin, 2004; 7) Council on Children and Families, Inc., 2003 WisKids Count Data Book, Madison, Wisconsin, 2003; 8) The Center on Wisconsin Strategy County Database available at: http://old.cows.org/toolkit/toolkit.asp; and 9) The Institute for Women's Policy Research, The Status of Women in Wisconsin, Washington, DC, 2004.

/2007/ No significant change. //2007//

/2008/ For the 2008 Title V Block Grant Application, the most current versions of the above data sources were used to update the principal characteristics of Wisconsin. These sources are: 1) U.S. Census Bureau, American Fact Finder, 2005 American Community Survey (http://factfinder.census.gov/), 2) the State of Wisconsin, 2005-2006 Blue Book, compiled by the Wisconsin Legislative Reference Bureau, 2005, 3) the Anne E. Casey Foundation Kids Count Online Data (www.aecf.org/kidscount/data.htm), 4) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Infant Births and Deaths, 2005 (PPH 5364-05). September 2006, 5) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Deaths, 2005 (PPH 5368-05). September 2006, and 6) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, (http://dhfs.wisconsin.gov/wish/) //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Population and Distribution

On April 1, 2000, Wisconsin's population was 5,363,675, according to the U.S. Census. Compared to the U.S. as a whole, with an overall 13% growth rate during the 1990s, Wisconsin's rate of growth was 10%. Wisconsin (along with 8 other states) lost a seat in the Congress in the reapportionment of the House of Representatives based on the final census counts.

/2008/ In 2004, Wisconsin's official population was 5,532,955. //2008//

/2009/ In 2006, Wisconsin's official population was 5,609,705. //2009//

/2010/ In 2007, Wisconsin's official population was 5,641,581. //2010//

Although Wisconsin is perceived as a predominantly rural state, it is becoming increasingly urbanized as reflected by the 2000 census. Sixty-eight percent of Wisconsin's population live in 20 (of 72) metropolitan counties (those counties with a city of 50,000 or more population plus those nearby counties where commuting to work is a link between the city and suburban counties); the remaining 32% of the population live in Wisconsin's 52 non-metropolitan counties. Wisconsin's population density varies greatly across the state. For example, the City of Milwaukee has 6,214 persons per square mile while Iron County, in the upper tier of northern Wisconsin has only eight people per square mile. Wisconsin's population is expected to grow with the largest amount of growth in the suburbs of metropolitan areas such as the Fox River Valley (Appleton, Green Bay, Menasha, Neenah, and Oshkosh), the counties surrounding the County of Milwaukee, and the western counties adjacent to the metropolitan area of Minneapolis/St. Paul. Despite this strong growth in major metropolitan areas, the City of Milwaukee, however, has experienced a loss of more than 31,000 residents during the 1990s, and Milwaukee County decreased by 19,000 persons.

/2008/ According to the 2005 Wisconsin Family Health Survey (Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, December, 2006), 29% of Wisconsin's household population lives in 47 nonmetropolitan counties, 11% lives in the city of Milwaukee, and 61% live in Milwaukee County and the other 25 metropolitan counties. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Population characteristics: Females make up 51% of the state's population and 34% of women live outside the metropolitan areas. The 2003 population estimate for the number of children under the age of 18 was 1,339,690 or about one-fourth of the state's population. The largest percentage of children live in the southeastern portion of the state (38%) and the smallest percent of children (9%) live in Wisconsin's northern tier.

/2008/ According to the 2005 American Community Survey, females made up 51% of the household population and males 49%. The median age was 37.9 years and 24% of the population were under 18 years and 13% were 65 years and older. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

In 2000, non-family households (defined as one person living alone or multiple unrelated persons living together) comprised more than one-third of all households in Wisconsin and more than half of these households were headed by females; traditional families (married couples with own children) comprised 24% of Wisconsin households, compared to 30% in 1970. Like the rest of the country, the 1950s "Ozzie and Harriet" picture has changed to the "Friends" of the 21st century. Additionally, family size has decreased: the average household size in Wisconsin 50 years ago was 3.4 persons; in 2000, it was 2.5 persons.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Vital statistics: Births to single mothers have increased slightly from 25% in 1991, 27% in 1993 and 1995, and 28% in 1996 and 1997 to 31% in 2003. The marriage rate in 2003 was 6.3 per 1,000 total population, lower than the U.S. 2003 provisional marriage rate of 7.6. The divorce rate per 1,000 residents has remained fairly static since 1993 hovering at 3.5 to 3.1 in 2003; this rate is consistently lower than the U.S. provisional divorce rate of 3.8 in 2003. Fifty-four percent of Wisconsin divorces in 2003 involved families with children under 18 years of age. In 2003, there were 42,040 deaths in Wisconsin for a rate of 8.4 per 1,000 population, slightly lower than recent years; this rate is similar to the U.S. rate.

/2007/ No significant change. //2007//

/2008/ In 2005, 33% of births were to unmarried women, a slight increase from 2004 when 32% of births were to unmarried women. The marriage rate in 2005 was 6.1 per 1,000 total population, lower than the 2004 rate of 6.2, and lower than the US 2005 provisional rate of 7.5 per 1,000 total population. The 2005 divorce rate in Wisconsin was 2.9 per 1,000 total population, lower than the 2004 rate of 3.0; the divorce rate in Wisconsin is lower than the U.S.

provisional rate of 3.6. Fifty-three percent of all 2005 Wisconsin divorces involved families with children under 18 years of age. In 2005, there were 46,544 resident Wisconsin deaths for a rate of 8.3 per 1,000; this rate is similar to the U.S. death rate. In 2005, there were 15 maternal deaths, compared to six in 2004 and nine in 2003. //2008//

/2009/ No significant change. //2009//

/2010/ In 2007, there were 72,757 live births to Wisconsin residents, 455 more than in 2006. In 2007, 36% of births were to unmarried women, continuing the trend from previous years. The marriage rate in 2007 was 5.7 per 1,000 total population, lower than the US 2007 provisional rate of 7.3. The 2007 divorce rate in Wisconsin was 2.9 per 1,000 total population, lower than the US rate of 3.6. Fifty-two percent of all 2007 Wisconsin divorces involved families with children under 18 years of age. In 2007, there were 46,711 deaths (a rate of 8.2 per 1,000) of Wisconsin residents, 66 more deaths than in 2006; the Wisconsin rate is similar to the 2007 US provisional rate of 8.0. In 2007, there were 15 maternal deaths, the same number as in 2005 and 2006. //2010//

Racial and ethnic characteristics: 2000 was the first year that census respondents were allowed to identify themselves as being of more than one race and about 1.2% of Wisconsin individuals selected multiple races. Therefore, comparisons of race/ethnic groups in Wisconsin are approached cautiously. From the 2000 census, single race and ethnic categories were the following: 88.9% White, 5.7% Black, 0.9% American Indian, 1.7% Asian (Hmong and Laotian are the two largest Asian groups), 1.6% other races, 1.2% two or more races, and 3.6% of Hispanic origin, any race. Wisconsin has 11 Indian reservations, and in 2000, the American Indian population was 47,228, a 21.1% increase from 1990.

/2007/ No significant change. //2007//

/2008/ According to the 2005 American Community Survey, for people reporting one race only, 89% were White, 6% Black, 1% American Indian, 2% Asian, less than 0.5% Native Hawaiian/Other Pacific Islander, 2% were some other race. One percent reported two or more races; 5% were Hispanic, and 86% were White non-Hispanic. //2008//

/2009/ Whites were the largest group at 90.5%, followed by blacks at 6.3%, American Indian at 1.0%, and Asian at 2.2%. Hispanics made up 4.7% of Wisconsin's population. //2009//

/2010/ No significant change. //2010//

In 2000, almost 76% of Wisconsin's Blacks lived in Milwaukee County. Two counties, Milwaukee and Racine, have Black populations that are more than 10% of the population; Milwaukee (24.6%) and Racine (10.5%). Also, for the first time, more than half of Milwaukee County's population was non-White. Thirty-nine percent of Wisconsin's children live in the southeastern portion of the state which includes the county and city of Milwaukee.

Selected indicators of child well-being in Wisconsin

Since 1990, Wisconsin's percentage of children has decreased from 14.9 in 1990 to 11.2% in 2000. Although poverty rates in 2000 for all race and ethnic groups decreased since 1990, the table below shows that minorities carry the burden of poverty in Wisconsin.

See Attachment for Section III. A. - Overview
(Table 1 - Children Living in Poverty)

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ According to the 2006 Wisconsin Family Health Survey, Wisconsin's minority and race ethnic groups have higher poverty rates than the majority white non-Hispanic population. The percentage of "poor" (<100 FPL) among all children 0-17 in Wisconsin is 13%, African American is 61%, Hispanic is 47%, and White is 6%. //2009//

/2010/ No significant change. //2010//

Income and Poverty

In 2004, Wisconsin's not seasonally adjusted unemployment rate was 4.9%, compared to the U.S. rate of 5.5%. Although seven percent of White women live in poverty in Wisconsin (one of the lowest percentages for White women in all but 7 states), 30% of Black women, 20% of American Indian women, 21% of Hispanic women, and 16% of Asian women live in poverty. The unemployment rate for Black women in Wisconsin is nearly twice as large as Black women nationally, and Black women here are three times as likely to live in poverty as White women. Children in Wisconsin are more likely to live in poor families; the disparity of the percentage of Black children living in poverty is six times greater than White children, is greater than any other state, and is exceeded only by the Black/White child poverty of Washington, D.C. The poverty rate for Black families in Wisconsin was 39%, the fourth highest in the country. Also, in 2000, nearly one-third of Blacks in metropolitan Milwaukee lived in poverty -- a rate seven times greater than for Whites in the same area. Overall, the percentage of children under 18 who live in poverty in Wisconsin is 11%. The range of the percentage of children who live in poverty by county is significant, from the counties with the highest poverty rates for children (Menominee at 39.6%, Milwaukee at 23.3.%, Vernon at 22.8%) to the counties with the lowest poverty rates for children (Ozaukee at 2.6%, Waukesha at 3%, and St. Croix at 3.9%). About 25% of American Indian and Asian American single-mother families in Wisconsin are poor, as is about one-third of Hispanic single--mother families.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ Wisconsin's 2008 unemployment rate was 4.7%, compared to the U.S. rate of 4.6%. However, these rates do not reflect the US economic crisis since the fall of 2008. In March 2009, Wisconsin's unemployment rate jumped to its highest rate in 26 years, 9.4%, passing the national rate of 9.0%. Furthermore, the decline of the auto industry has hit Wisconsin especially hard, with the southeast portion of the state, where General Motors has plants it has closed in Beloit and Janesville. The Janesville MSA (Metropolitan Statistical Area) reported the highest rate at 13.5%. Although Wisconsin's overall poverty rates are lower than the US rates for 2000 and 2007 (2000: US - 12.2%, WI - 8.9%; 2007: US - 13.0%, WI - 10.8%), our rates have increased more than the national rates. Furthermore, Wisconsin's children are adversely affected by parents unemployment, shown by these rates for child poverty (2000: US - 17.3%, WI - 11.8%; 2007: US - 18.0%, WI - 14.4%). //2010//

Wisconsin's Racial and Ethnic Composition and Health Disparity

It is expected that Wisconsin's population will continue to increase in racial and ethnic diversity to further enrich the state. The population of Wisconsin is primarily non-Hispanic White (89% in 2000). The racial and ethnic groups of Blacks, American Indians, Southeast Asians, and Hispanics report a youthful age structure with proportionately more women entering the childbearing ages.

In 2000, Blacks represented the largest racial minority group comprising about 5.7% of the total

population. The Hispanic-origin population (of any race) constituted the second largest minority group in Wisconsin (3.6%). Although births to Hispanic women still constitute a small percentage (7.9%) of Wisconsin's total 2003 births, this percentage of Hispanic births has tripled in the last ten years. The American Indian population in Wisconsin includes several distinct nations: the Chippewa (Ojibwa), Oneida, Winnebago, Menominee, Stockbridge-Munsee, and the Potawatomi. The 2000 Census count was 47,228 American Indians in Wisconsin, an increase from 38,986 in 1990. The Southeast Asian population (includes people of diverse national origins to include Hmong, Laotian, Vietnamese, Thai, and Cambodian) has grown from 52,782 people in 1990 to 88,763 in 2000.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ In 2006, Blacks and Hispanics were the largest minorities at 6.3% and 4.7% respectively, followed by Asicans (2.2%) and American Indians (1.0%). //2009//

/2010/ No significant change. //2010//

The attached table, from the Anne E. Casey Foundation, Kids Count 2004 Data Book Online, presents major indicators of child well-being in Wisconsin compared to the U.S. in 2001. See Attachment for Section III. A. - Overview (Table 2 - Child Well-Being Indicator).

Compared to other states, using these indicators, Wisconsin's overall rank is 11. These indicators do not reflect the significant disparities by racial/ethnic group in the state; selected indicators are discussed below:

/2007/ The 2005 On-line Anne E. Casey's Foundation's Kids Count ranked Wisconsin #10. //2007//

/2008/ The 2006 On-line Anne E. Casey's Foundation's Kids Count rank overall for Wisconsin in 2003/2004 was #13. //2008//

/2009/ The 2007 On-line Anne E. Casey's Foundation's Kids Count rank overall for Wisconsin in 2004/2005 was #12. //2009//

/2010/ The 2008 On-line Anne E. Casey's Foundation's Kids Count rank overall for Wisconsin in 2005/2006 was #12. //2010//

• Infant mortality -- Often used as a measure of a society's overall well-being, is a significant issue in Wisconsin. The overall infant mortality in 2003 was 6.5 per 1,000 live births; the White rate was 5.3, a slight decrease from 5.5 in 2000, and a marked decrease from 7.0 in 1993. The Black infant mortality rate in 2003 was 15.3; in 1997 it was at its lowest for the past two decades at 13.4. Since then it increased steadily, to 18.7 in 2001, and aside from some fluctuations to the 1997 rate, it is essentially the same now as it was in 1980 at 18.2. In fact, because Black infant mortality has improved in other states, from 1999-2001 Wisconsin dropped to among the lowest, ranking 32 among 34 states. There are too few infant deaths in the other racial/ethnic groups to calculate annual rates. Therefore, the following three-year averages from 2001-2003 are American Indian: 12.9, Hispanic: 6.9, Asian (Laotian/Hmong): 7.6.

/2007/ Wisconsin's overall infant mortality in 2004 was 6.0 deaths per 1,000 live births; the White rate was 4.5 per 1,000, and the Black infant mortality rate was 19.2; the ratio of the Black infant mortality rate to the White rate was 4.3. For the other racial/ethnic groups in Wisconsin, we calculated three-year averages for 2002-2004; they are: American Indian at 9.0, Hispanic at 6.2, and Asian (Laotian/Hmong) at 8.3. //2007//

/2008/ Wisconsin's overall infant mortality rate in 2005 was 6.6 deaths per 1,000 live births; the White rate was 5.6 per 1,000, and the Black infant mortality rate was 15.0; the ratio of the Black infant mortality to the White rate was 2.7. For the other racial/ethnic groups in Wisconsin, we calculated three year averages for 2003-2005; they are: American Indian at 7.5, Hispanic at 6.2, and Asian (Laotian/Hmong) at 8.6. //2008//

/2009/ Wisconsin's overall infant mortality rate in 2006 was 6.4 per 1,000 live births (462 infants under the age of one year died); the White rate was 4.9 per 1,000 and the Black infant mortality rate was 17.2 per 1,000 live births. The ratio of the Black infant mortality rate to the White rate was 3.5. For the other racial/ethnic groups in Wisconsin, we calculated three year averages for 2004-2006; they are: American Indian at 8.1, Hispanic at 6.0, and Laotian/Hmong at 6.5. //2009//

/2010/ Wisconsin's overall infant mortality rate in 2007 was 6.4 per 1,000 live births (469 infants under the age of one year died), the same rate as 2006. The White rate was 5.3 per 1,000, and the Black rate was 14.5 per 1,000. The ratio of the Black infant morality rate to the White was 2.7. For the other racial/ethnic groups in Wisconsin, we calculated three year averages for 2005-2007; they are: American Indian at 9.5, Hispanic at 6.3, and Laotian/Hmong at 6.0. //2010//

• Low birth weight/preterm -- In 2003, in Wisconsin, 6.6% of all births were infants with low birth weight, Black infants (13.2%) were about 2 times as likely as White infants (5.8%) to be born low birth weight. Also in 2003, 11.0% of infants were born prematurely, with a gestation of less than 37 weeks; non-Hispanic Black women had the highest percentage of premature babies at 16.7%, followed by American Indian and Laotian/Hmong women at 11%, and White Hispanic women at 10%.

/2007/ In 2004, 7.0% of all births were infants with low birth weight; the rate for Black infants was 13.7%, the rate for White infants was 6.3%; the rates for American Indian, Hispanic, and Asian (Laotian/Hmong) infants were 5.9%, 6.6%, and 7.0% respectively. In 2004, 11.0% of all births were born prematurely (the same rate as 2003); non-Hispanic Black women had the highest percentage of premature babies at 17.1%, followed by American Indians at 13.8%, Asian (Laotian/Hmong) at 11.5%, and Hispanics at 10.6%. //2007//

/2008/ In 2005, 7.0% of all births were infants with low birth weight; the rate for Black infants was 13.7%, the rate for White infants was 6.3%, the rates for American Indian, Hispanic, and Asian (Laotian/Hmong) infants were 5.4%, 6.5%, and 6.8% respectively. In 2005, 11.3% of all births were premature; non-Hispanic Black women had the highest percentage of premature babies at 17.9%, followed by Asian (Laotian/Hmong) at 11.6'%, Hispanic at 11.5%, and American Indian at 11.4%. Teenagers, women who are unmarried, who smoked during pregnancy, and with less than a high school education are at the highest risk of having a premature baby. //2008//

/2009/ In 2007, 6.9% (4,994) of all births were infants with low birth weight; the rate for Black infants was 13.5%, the rate for White infants was 6.2%, the rates for American Indian, Hispanic, and Laotian/Hmong were 6.8%, 6.2%, and 6.1% respectively. In 2006, 11.2% (8,104) infants in Wisconsin were born prematurely (with a gestation of less than 37 weeks). Non-Hispanic Black women had the highest percentage of premature babies at 17.8%, followed by teenagers less than 18 years old at 15.3%, women who were unmarried (13.6%), women who smoked during pregnancy (13.0%), and women with less than a high school education (13.5%). //2009//

/2010/ In 2007, 7.0% (5,089) of all births were infants with low birth weight; the rate for Black infants was 13.5%, the rate for White infants was 6.2%, the rates for American Indian, Hispanic, Laotian/Hmong and other Asians were 7.1%, 6.4%, 7.9%, and 7.7%. In 2007, 11.1% (8,072) of infants in Wisconsin were born prematurely (with a gestation of less than 37 weeks). Non-Hispanic Black women had the highest percentage of premature babies at 17.3%, followed by teenagers less than 18 years old at 17.2%, women who were unmarried 13.6%, women who smoked during pregnancy 13.4%, and American Indian

women 13.3%. //2010//

• First trimester prenatal care -- Overall, in 2003, 84.7% of pregnant women in Wisconsin received first trimester prenatal care. Among Black and American Indian women, 73.5% and 71.0% respectively, received prenatal care during the first trimester, compared to 88.3% for White women, followed by Hispanic women with 71.0%, and Laotian/Hmong with 54.2%.

/2007/ In 2004, 85% of pregnant women received first trimester prenatal care. Black, Hispanic, and American Indian women, had comparable rates of prenatal care at 76.5%, 71.9%, and 71.7% respectively. Asian (Laotian/Hmong) women had the lowest rate of first trimester prenatal care at 56.6%. //2007//

/2008/ In 2005, 85% of pregnant women received first trimester prenatal care. Black, Hispanic, and American Indian women had comparable rates of prenatal care at 75.7%, 72.7%, and 74.4% respectively. Asian (Laotian/Hmong) women had the lowest rate of first trimester prenatal care at 56.7%. //2008//

/2009/ In 2006, 83.8% of pregnant women received first trimester prenatal care. The race/ethnic group with the highest rate was white women at 87.4%, followed by African American women at 74.4%, Hispanic/Latino at 72.3%, American Indian at 71.8%, and Laotian and Hmong at 58.8%. From 1996 to 2006, the proportion of women receiving first-trimester prenatal care increased within each race/ethnicity group except whites. The increase was especially striking among African American and Laotian/Hmong women from 66% to 74% for blacks and 47% to 59% for Laotian and Hmong. //2009//

/2010/ In 2007, 82.8% of pregnant women received first trimester prenatal care. The race/ethnic group with the highest rate was White women at 86.5%, followed by other Asian women at 83.0%, African American women at 73.4%, Hispanic/Latino women at 71.1%, American Indian women at 70.2%, and Laotian/Hmong at 55.2%. //2010//

• Teen birth rate -- In 2003, for teens <20 years, there were 6,317 births (rate of 32.5 per 1,000); by race/ethnic groups, there are disparities with Hispanic teens at the highest rate at 104.9, followed by Black teens (99.9), American Indian teens (76.2), and White teens (20.3). In 2003, as a percentage of all births, 9% were to teens; 24% of Black births to teens, 21% of Laotian/Hmong births to teens, 19% of American Indian births to teens, 16% of Hispanic births to teens, and 6% of White births to teens. Of the 50 largest U.S. cities, Milwaukee had the second highest percent of total births to teens with 2,021 births; these Milwaukee teen births represented 31% of teen births statewide.

/2007/ In 2003, for teens <20 years, there were 6,087 births (rate of 30.5/1000: by race/ethnic groups, there are disparities with Hispanic teens at the highest rate of 97.2, followed by Black teens (94.3), American Indians (60.5), and White teens (19.0). In 2004, as a percentage of all births, 8.7% were to teens; 23% of Black births to teens, 21% of Laotian/Hmong births to teen, 19% of American Indian births to teens, 16% of Hispanic births to teens, and 6% of White births to teens. //2007//

/2008/ In 2005, for teens <20 years, there were 6,093 births (rate of 30.5/1000, the same as 2004), or 8.5% of all births in Wisconsin. The following shows the overall decline in teen birth rates by race/ethnicity during the past decade.

Teen birth rates, for 15-19, by race/ethnicity in Wisconsin, 1995 compared to 2005:

Race/ethnicity
Total for 1995=38.8, for 2005=30.5
White for 1995=26.3, for 2005=19.2
Black for 1995=141.8, for 2005=94.5

Hispanic for 1995=103.4, for 2005=89.8
//2008//

/2009/ In 2006, for teens <20 years, there were 6,100 births (rate of 30.6 per 1,000), or 8.4% of all births in Wisconsin. Teen birth rates for 15-19 by race/ethnicity in Wisconsin, 1996 to 2006:

Race/ethnicity
Total for 1996=30.1, for 2006=30.6
White for 1996=24.9, for 2006=19.1
Black for 1995=133.3, for 2006=93.8
American Indian for 1995=73.2, for 2006=74.4
Hispanic for 1996=97.4, for 2006=94.6
//2009//

/2010/ In 2007, for teens <20 years, there were 6,320 births (rate of 32.4 per 1,000), or 8.7% of all births in Wisconsin. Teen birth rates for <20 years by race/ethnicity in Wisconsin, 1997 to 2007:
Race/ethnicty
Total for 1997=36.3 for 2007=32.4*
White for 1997=24.9, for 2007=19.4*
Black for 1997=131.2, for 2007=100.2*
Amer Indian for 1997=79.5, for 2007=101.3*
Hispanic for 1997=87.0, for 2007=102.6*
****includes births to mothers under 15 years of age. //2010//***

• Leading causes of death -- The attached table shows the five leading, underlying causes of death in Wisconsin, compared to race groups, all ages, 2003.*

See Attachment for Section III. A. - Overview
(Table 3a - Percent of Leading Underlying Causes of Death by Race, Wisconsin, 2003)

In 2003, the two leading causes of death statewide and for Whites were cancer and heart disease at more than 50%; 42% of all Blacks deaths were from heart disease or cancer, and the percentage of American Indians and Asians dying from heart disease and cancer were similar at 39.9% and 38.5% respectively. Chronic health conditions represented a smaller proportion of overall deaths for minorities because of the higher proportions of deaths in younger age groups such as injury or accidents, which occur more frequently. The third leading cause of deaths for American Indians and Asians was accidents at 10%, compared to 5% overall for Whites and Blacks. Violence (homicide) was the fifth leading cause of death among Blacks at 5% and was not a leading cause of death among other groups or statewide. About 6% of all American Indian deaths were from diabetes, but is not among the five leading causes of deaths for other groups or statewide; most of these American Indian deaths from diabetes were between the ages of 45-74.

/2007/ No significant change. //2007//

/2008/ In 2005, the three underlying causes of death were diseases of the heart, malignant neoplasms (cancer) and cerebrovascular diseases (stroke), accounting for 55% of Wisconsin resident deaths.

See Attachment for Section III. A. - Overview
(Table 3b - Percent of Top 5 Leading Underlying Causes of Death by Race, Wisconsin 2005)
//2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

FACTORS IMPACTING UPON THE HEALTH SERVICES DELIVERY ENVIRONMENT

Medicaid is the single most important government program to provide access to health care for low and middle income children and families. Today, about 1 in 7 Wisconsin residents rely on Medicaid for comprehensive health care coverage they would not otherwise be able to afford. Four major groups received medical services through Medicaid: the aged, the blind/disabled, the Healthy Start population, and recipients who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible recipients, well over half were eligible through AFDC or Healthy Start, accounting for 19% of Medicaid expenditures. The aged/blind/disabled make up approximately 35% of the eligible population and account for 81% of the program expenditures.

The Wisconsin Medicaid budget continued to increase in 2004, in concert with national budget trends for Medicaid. Total expenditures for the program, rose by 9% in the 2003-04 state fiscal years, compared with the previous state fiscal year. Total expenditures were at $4.4 billion in all funding sources. These budget figures include Medicaid, Badger Care, Family Care, and Senior Care drug benefits. Governor Doyle's administration has preserved the health care safety net for vulnerable populations and has not cut Medicaid services or eligibility.

/2007/ No significant change. //2007//

/2008/ BadgerCare Plus Legislative Proposal
In announcing his "Affordability Agenda" in January 2006, Governor Jim Doyle stated that "no child should ever be without health insurance." The policy solution to ensure that all of Wisconsin's children have access to health care is creation of a single health care safety net--BadgerCare Plus. The detailed proposal, being considered in the 2007 state legislative session for implementation starting January 2008, describes Wisconsin's strategies for achieving the four strategic goals of the initiative.
1. Cover all children
2. Provide coverage and enhanced benefits for pregnant women
3. Simplify the program
4. Promote prevention and healthy behaviors

BadgerCare Plus will merge Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families. Coverage will be expanded to seven new populations.
1. All children (birth to age 19) with incomes above 185 percent of the federal poverty level (FPL)
2. Pregnant women with incomes between 185 and 300 percent of the FPL
3. Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL
4. Caretaker relatives with incomes between 44 and 200 percent of the FPL
5. Parents with children in foster care with incomes up to 200 percent of the FPL
6. Youth (ages 18 through 20) aging out of foster care
7. Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent on depreciation calculations

In addition, Wisconsin will streamline eligibility; assist employees in purchasing quality, employer-sponsored coverage; and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967. The state is also seeking federal approval for the changes, which, like the BadgerCare Plus legislative and budget process, has an uncertain timeframe.

ACCESS Summary and Update

ACCESS is a set of online tools for public assistance programs that allows customers and prospective customers to assess eligibility for programs, check case benefits and report case

changes. Significantly, in mid-2006, an upgrade allowed for limited online program application. For many, this is an appealing alternative to office visits and phone calls. Although they may not own a personal computer, a growing number of customers do have access to computers -- through friends or family, at work, at school or at the library. Others use online tools with the help of staff/volunteers at food pantries, clinics, HeadStart programs, Community Action Agencies, WIC clinics, Job Centers, etc.

The goals of the ACCESS project are to:
• Increase participation in FoodShare, Medicaid, and other programs
• Improve customer service and satisfaction
• Improve FoodShare payment accuracy
• Ease workload for local agencies

Some of the key features of ACCESS are:
• Design was based on direct input from customers. More than 15 focus groups and design review sessions were undertaken with low-income residents of Wisconsin
• Friendly, encouraging text written at a 4th grade reading level
• Personalized pages, results and next steps
• Quick, simple, intuitive navigation
• For some people, ACCESS is the first website they've ever used
• Assurance about privacy. Some are nervous about giving personal information online

The major components of ACCESS are:
• Am I Eligible? -- A 15-minute self-assessment tool (launched 8/16/04) for:
*FoodShare
*All subprograms of Medicaid
*SeniorCare and Medicare Part D
*Women, Infants and Children (WIC)
*The Emergency Food Assistance Program
*School meals and summer food assistance
*Tax credits (EITC, Homestead and Child Credit)
*Home Energy Assistance

• Check My Benefits -- An up-to-date information segment (begun 9/30/05) that includes:
*Displays information about Medicaid, FoodShare, SeniorCare, and SSI Caretaker Supplement benefits
*Information displayed is based on why customers call their workers
*Provides data directly from CARES (automated eligibility system)
*Data is "translated" to make it more understandable
*Data is furnished real time at account set-up, and is then updated nightly

• Apply For Benefits -- An online application for FoodShare, Medicaid and the Family Planning Waiver program (launched 6/2/06)

Medicaid Enrollment Update

Enrollments continued to grow for the Wisconsin Medicaid program, following a trend nearly a decade old. For state fiscal year 2005-2006, enrollments grew by 3.3% from the previous year in the "family Medicaid" segment of the program -- Medicaid, Healthy Start for pregnant women, infants and children, and the SCHIP program known as BadgerCare. For 2005-2006, the total of family Medicaid enrollees grew to 414,809 from 401,622. Overall, the average number of Medicaid enrollees increased to 651,768 -- a 3.6% increase from the previous year.

Total Medicaid expenditures for the most recent completed state fiscal year of 2005-2006 were at $4.5 billion. Governor Doyle's BadgerCare Plus proposal, currently being considered in the Legislature, carries with it the central goal of covering all Wisconsin children with its broad array

of services. //2008//

/2009/ In February, 2008, the BadgerCare Plus program began implementation statewide. The program provides a Standard Plan that covers usual Medicaid services and a Benchmark Plan for members with incomes greater than 200% FPL that is more restrictive with higher co-pays. By the end of February, more than 71,000 additional children and families have received comprehensive health insurance coverage. Of that total, 13,500 parents and children reside in Milwaukee County, the state's most populous and highest need urban area. The overall increase far exceeds the state's budget projections for the program's first 12 to 18 months.

Due to the expansion and consolidation of family Medicaid programs into BadgerCare Plus, the "family Medicaid enrollment" category continues to grow. In the most recently available figures, the total family Medicaid program enrollees now under "BadgerCare Plus" was 555,373, as of February 29. This total is up from about 484,000 on February 11. //2009//

/2010/ The MCH Program has been participating in the planning of Medicaid Pay-for-Performance measures related to MCH populations, including for birth outcomes. Managed care plans will be asked to submit comprehensive plans for addressing the medical needs of women at high risk for poor birth outcomes. The MCH Chief Medical Officer for the Bureau of Community Health Promotion has been included as a reviewer of those plans. In addition, a registry identifying women who have had previous poor birth outcomes will be developed so that HMO plans can appropriately manage their care. MCH staff will be attending a day-long Wingspread best practices seminar sponsored by Medicaid, with HMO managers and medical staff, and will be sharing work conducted through the Disparities in Birth Outcomes Initiative on evidence-based, best, and promising practices. //2010//

Wisconsin Works (W-2)

Wisconsin's Temporary Assistance to Needy Families program is referred to as the Wisconsin Works program. It replaced the Aid to Families with Dependent Children program, and it requires recipients to work. As of December 2004, total enrollment in the Wisconsin Works program (W-2) was about 10,800. The 2004 average monthly enrollment was 12,060.

/2007/ No significant change. //2007//

/2008/ A Doyle administration proposal in the 2007 Wisconsin Legislature would extend the amount of time a mother or other custodial parent of an infant could receive a W-2 grant from 12 weeks to 26 weeks. Mothers would be eligible to receive the $673 monthly cash benefit and would not be required to participate in W-2 employment until their infant is 26 weeks old, allowing for additional time to bond and care for their newborns during this critical attachment period.

In addition, beginning in January 2008 high risk pregnant women would be eligible for cash benefits of $673 per month, during the third trimester. This cash benefit would be limited to women who do not have children and are unmarried. //2008//

/2009/ No significant change; the above proposal was not enacted into law. //2009//

/2010/ As part of the DHS Healthy Birth Outcomes Initiative, the InterDepartmental Service Integration Office successfully lead the development of the W-2 Fast Track Referral and Application process for high risk pregnant women, mothers and custodial fathers with high risk children from 0-5 years of age. This collaboration involved the Milwaukee W-2 Section Office, Division of Public Health S.E. Regional Office (SERO), Milwaukee Health Department's Empowering Families in Milwaukee (EFM), and W-2 Agencies. The Black Health Coalition of Wisconsin (BHCW) was included in this initiative several months later, as requested by the SERO. A total of 4 "fast track referrals" to W-2 have been made; 2

from EFM and 2 from the BHCW. It appears the problems that existed when this initiative began no longer exist; per EFM most of their families are already involved with W-2 and don't need referrals. The BHCW reports that most of the W-2 issues reported by their clients are with on-going services e.g., unwarranted sanctions, unrealistic work activities expectations, etc. The Service Integration Office and the Division of Public Health SERO will continue to monitor and facilitate meetings as needed with Empowering Families of Milwaukee, the Black Health Coalition of Wisconsin, and the W-2 Agencies. //2010//

Blue Cross Blue Shield Grants

Blue Cross Blue Shield asset conversion is an endowed fund that will fund public health projects "in perpetuity". Therefore, we will continue to provide overall project and grant-writing assistance to interested agencies into the future. The first grant cycle began in 2004.

Maternal and child health proposals were well-represented among grant award winners in the first award cycle of Wisconsin's Blue Cross Blue Shield public health initiative. In the implementation (large-grant) category for the University of Wisconsin - Wisconsin Partnership Fund, for example, 10 of 13 funded projects had at least partial focus on maternal issues, children, or families. The funded value of these grants is approximately $4.5 million over three years. These funded projects are:
1. Madison Community Health Center (Adolescents)
2. DHFS (Oral Health)
3. Dane Co. Dept. of Human Services (Home Visiting)
4. WI Women's Health Foundation (First Breath)
5. Aurora Medical Center in Washington County (Fit Kids)
6. Milwaukee Birthing Project (Infant Mortality)
7. Wisconsin Association for Perinatal Care (Peridata)
8. Aurora/Sinai (Safe Mom/Baby -- Domestic Violence)
9. LaCrosse Schools (Healthy Lives for Kids with Disabilities)
10. Great Lakes Inter-Tribal Cooperative (Healthy Children/Strong Families)

The DHFS oral health project deserves particular mention in this context. Title V block grant funded staff had lead responsibility to write one of the only Department-sponsored projects because of the high priority the Department places on oral health. Under the Department's directive, however, virtually all of the $450,000 in the oral health project award is being passed through to community entities, including mini-grants to local health departments in the state's Northern Region. These health departments will implement several preventive strategies with a pediatric focus, including a fluoride varnish initiative.

/2007/ No significant change. //2007//

/2008/ In the 2007 round of funding, six maternal and child-oriented Wisconsin Partnership Program (WPP) proposals were awarded by both medical schools in this continuing public health initiative. MCH proposals have been well-represented among awardees in the early years of these programs, so we will continue to provide overall project and grant-writing assistance to agencies in the future.

Large-grant funded implementation projects (up to $450,000) in 2007 were:
1. Covering Kids and Families (University of Wisconsin)
2. Covering Kids and Families (Medical College of Wisconsin)
3. Fight Asthma Milwaukee Allies
4. Milwaukee Kids: Drive Me Safely
5. Milwaukee Nurse Family Partnership Program
6. HealthWatch Wisconsin

The Blue Cross Blue Shield asset conversion endowment, controlled by the state's two medical

schools, amounts to nearly $700 million in total. As such, it is one of the largest such Blue Cross/Blue Shield endowments in the country. The first grant cycle began in 2004; grant funding will continue "in perpetuity." //2008//

/2009/ Children and families continue to receive a significant number of awards from the Blue Cross/Blue Shield asset conversion endowment made in 2007 for a 2008 start date. Of the 10 major awards worth roughly $5 million awarded by the University of Wisconsin program, seven had a major focus affecting children and families.

Those seven grant proposals are:
1. Keeping Kids Alive in Wisconsin;
2. Eco-cultural Family Interview Project;
3. Expanding and Sustaining the 'Safe Mom/Safe Baby' Project;
4. Allied Drive Early Childhood Initiative;
5. Underage Drinking -- A Parent Solution;
6. It Takes a Community to Help a Smoker;
7. Expanded Community Role in the Milwaukee Homicide Review Commission.

At the Medical College of Wisconsin, the second medical school to receive Blue Cross/Blue Shield funding, the Healthier Wisconsin Partnership Program awarded 13 large-grant proposals worth about $5.8 million in early 2008. Of those 13 winning grants, 3 were substantially oriented to children and families:

1. Healthy Youth: Strong and Connected,
2. Making Milwaukee Smile,
3. Salud de la Mujer: Community Developed Materials to Increase Health Literacy in a Latino Community. //2009//

/2010/ The 2008 grant cycle at the Wisconsin Partnership Fund for a Healthy Future (UW School of Medicine and Public Health) was curtailed due to the sharp stock market downturn late in 2008.

Because the schools' endowments are heavily reliant on strong stock market performance, the stock market downturn caused the Partnership Fund's Oversight and Advisory Committee (OAC) to limit its grant-making activity. Moreover, it took steps to reduce funding for existing grants for the first time in the initiative's history.

In December 2008, the UW OAC approved but didn't fund three "large-grant" implementation projects. The grant-making body said its ability to actually fund the grant proposals would hinge on the overall recovery of the endowment's balance. All approved (but not funded) proposals dealt with children and families:
1)"Assessing the Nutrition Environment in Wisconsin Communities," Wisconsin Partnership for Activity and Nutrition
2)"Fit Families, Fit Communities," Portage County CAN
3)"Implementing Strategies to Increase Breastfeeding Rates in Milwaukee County," Milwaukee County Breastfeeding Coalition

In early 2009, the Medical College of Wisconsin's Healthier Wisconsin Partnership Program decreased both the number of proposals they funded and the funding level. Five Developmental Awards were funded up to $40,000 per award and 3 Impact Awards were funded up to $300,000. The successful large grant proposals included the following:
1) Changing the Culture of Risky Drinking Behavior: Underage Access
2) Collaborative Response to the Growing Wisconsin Health Workforce Crisis
3) Nuestros Ninos Nuestro Futuro (Our Children Our Future) //2010//

/2008/ Licensed Midwives

New legislation became effective May 1, 2007 licensing midwives without a nursing degree. In Wisconsin, in 2005, about 1,100 Wisconsin infants were born outside a hospital. This law also frees certified nurse midwives from having a written agreement with a health care authority and allows them to mentor and train lay midwives. Wisconsin's MCH Program is supportive of the lay midwives, and organizes meetings about twice a year, in part, to facilitate communication between the state and the midwives who serve populations, e.g., the Amish, who may seek care from non-traditional health care providers. //2008//

/2009/ Certified midwives partnered with the UW Waisman Center to apply for and received a March of Dimes grant for educational materials for Wisconsin's Amish and Mennonite communities to promote prenatal, postpartum and infant care including newborn screening for metabolic disease and newborn hearing screening. //2009//

/2010/ Licensed Professional Midwives are collaborating with area hospital OB/Gyn practitioners creating a direct entry pathway from home to hospital setting. They are also in the process of requesting approval to be certified Medicaid providers. //2010//

/2008/ Tobacco Funding

The current Wisconsin Tobacco Prevention and Control Program is a funded $10 million dollar program, focusing on providing funding to local tobacco coalitions throughout the state, youth program designed to reduce and prevent smoking among youth, cessation services, media and counter marketing, surveillance and evaluation of tobacco related data, and programs focused on reducing tobacco use among disparity populations. Governor Doyle has proposed an increase in tobacco program funding from $10 million to $30 million dollars, and has proposed a statewide smoking ban. He also proposed an increase to the current cigarette tax of $0.77 to a $1.25 tax per pack, which passed. //2008//

/2009/ The current Wisconsin Tobacco Prevention and Control Program is a $15 million dollar program, focusing on providing funding to local tobacco coalitions throughout the state, youth programs designed to reduce and prevent smoking among youth, treating tobacco dependence services, eliminating the exposure to secondhand smoke through policy development, media and counter marketing campaigns, surveillance and evaluation of tobacco related data, and programs focused on reducing tobacco use among disparity populations. //2009//

/2010/ The Wisconsin Tobacco Prevention and Control Program was reduced to $6,850,000 general purpose revenue through June 30, 2009. The State budget for 2010-2011 is not yet finalized. The Center for Disease Control and Prevention funding is $1,191,137. A statewide smoke-free air workplace and public place policy will go into effect July 5, 2010. The Governor's budget includes a $0.75 cigarette tax effective 09/01/2009. //2010//

/2008/ Oral Health Funding

The Wisconsin Department of Health and Family Services initiated a one-time grant program to create or improve local community efforts to increase access to oral health services. The purpose of the project is to improve access to preventive and restorative oral health services for children - including those who are eligible for Medicaid or BadgerCare, and those who are uninsured or underinsured. In addition, specific target populations were pregnant women and persons with disabilities. Grants in the amount of $4.1 million were awarded to various organizations and agencies throughout the state for this Dental Access initiative. Grant awards ranged between $25,000 and $500,000. //2008//

/2009/ This was a one-time Dental Access grant program. There were 16 projects that received funding. Some of the projects expended all of their funds by the end of 2007 or early 2008. There are a few projects that requested and were granted extensions. All of these contracts end

on September 31, 2008. There will be no funding or projects from this source in 2009. //2009//

/2010/ In 2009 the last round of HRSA funding for Wisconsin's school-based sealant program, Seal-A-Smile, was received. The Oral Health Program has aggressively sought additional funding to support the valuable work of the Seal-A-Smile program and has recently submitted a program specific proposal to HRSA that would nearly triple current funding to Seal-A-Smile. Additionally in 2009, WI Oral Health Program was one of only sixteen states nationwide to receive funding through a CDC Cooperative Agreement. The Cooperative Agreement funds infrastructure and capacity building and has allowed for the creation of three new positions focused on epidemiology, fluoride, and sealants. Annual funding for this renewable contract is $300,000/yr for the first five years. //2010//

Reproductive Health and Family Planning Services, Waiver and Outreach Efforts

According to the latest report prepared by the Alan Guttmacher Institute, 634,250 (among the 1,235,190 women in Wisconsin ages 13-44) are estimated to be at risk of unintended pregnancy and in need of contraceptive services and supplies. Of this number, 230,060 are estimated to be at risk of unintended pregnancy and in need of publicly supported contraceptive services: this includes 95,350 under age 20, and 134,710 between the ages of 20-44 and under 250% of poverty. This group is at high risk for unintended pregnancies, and the health, financial, and social consequences to women, children, and families. Low income women are particularly vulnerable to the consequences.

/2007/ No significant change. //2007//

/2008/ According to the latest report prepared by the Alan Guttmacher Institute, 640,450 (among the 1,239,470 women in Wisconsin ages 13-44) are estimated to be at risk of unintended pregnancy and in need of contraceptive services and supplies. Of this number, 235,120 are estimated to be at risk of unintended pregnancy and in need of publicly supported contraceptive services: this includes 95,330 under age 20, and 139,790 between the ages of 20-44 and under 250% of poverty. This group is at high risk for unintended pregnancies, and the health, financial, and social consequences to women, children, and families. Low income women are particularly vulnerable to the consequences. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

The Wisconsin Medicaid Family Planning Waiver was approved and implemented January 1, 2003, to increase access to family planning services and supplies for low income women (below 185% poverty) ages 15-44. Through the outreach efforts of family planning providers under contract with the MCH-Family Planning Program, over 58,000 women were enrolled in the Waiver Program as of March 31, 2005. This represents approximately 18% of the estimated need for publicly supported services and supplies.

/2007/ Over 64,000 women were enrolled in the Waiver Program as of March 31, 2006, representing approximately 22.7% of the estimated need. //2007//

/2008/ The Wisconsin Medicaid Family Planning Waiver was approved and implemented January 1, 2003, to increase access to family planning services and supplies for low income women (below 185% poverty) ages 15-44. Through the outreach efforts of family planning providers under contract with the MCH-Family Planning Program, approximately 63,000 women were enrolled in the Waiver Program as of December 31, 2006. This represents approximately 22% of the estimated need for publicly supported services and supplies. The FPW will be submitted to include males. //2008//

/2009/ The Wisconsin Medicaid Family Planning Waiver was renewed as of January 1, 2008. Income eligibility was increased from 185% to 200% for women ages 15-44. Approximately 59,799 women were enrolled in the FPW as of December 31, 2007. This represented 21% of the estimated eligibility for the FPW. Enrollment decreased from 2006 to 2007. Additional enrollment process necessitated by the Deficit Reduction Act requirements probably resulted in decreased enrollment. //2009//

/2010/ 57,459 women were enrolled in the FPW by 12/31/08. As anticipated, the Deficit Reduction Act provisions resulted in decreased enrollment. Outreach activities and changes in enrolment processes may reverse this trend. Only 20% of the eligible population was enrolled in 2008. //2010//

Increasing awareness about the Medicaid Family Planning Waiver, how to enroll, and how to obtain services is a high priority within the MCH-Family Planning Program. The goal is to provide information that will allow women to make informed decisions regarding enrollment. Providers will be encouraged to further collaborate with other community health providers in 2005 and 2006 to increase awareness and to increase access to services. A related priority will be to make contraceptive and related reproductive services more convenient: to reduce office protocols and other administrative barriers to services. Making services more convenient has considerable potential to enhance outreach success.

/2007/ In January 2006 Wisconsin implemented a five year program plan to increase early intervention and detection of pregnancy. The goals of the program are to increase enrollment into the Family Planning Waiver, increase access to emergency contraception, increase use of dual protection, and make reproductive services more convenient. //2007//

/2008/ In 2007, Wisconsin will launch a new adolescent pregnancy prevention and Medicaid Family Planning Waiver initiative in Milwaukee to reach adolescents and young adults at high risk of unintended pregnancy. //2008//

/2009/ The Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) which encompasses two clinics, a large local health department and a local community-based organization continues to make progress toward the following goals: 1) develop a Milwaukee driven, community-based partnership focused on adolescent pregnancy prevention for African Americans, ages 15-19; 2) increase the Medicaid Family Planning Waiver enrollment in Milwaukee; and 3) successfully implement the evidenced-based, dual strategy for addressing adolescent pregnancy prevention. A key challenge for this initiative is to find innovative ways to directly engage African American youth from non-traditional and ethnically diverse communities to deliver evidenced-based teen pregnancy and STD prevention messages.

The MAPPP will make significant numerical and qualitative inroads to increase participation in the Medicaid Family Planning Waiver and will establish clear communication and coordination mechanisms with Milwaukee organizations charged with teen pregnancy, teen parenting, adolescent reproductive health services, and advocacy. MAPPP will be forming a Teen Advisory Committee to help them increase the outreach and efficacy of the Family Planning Waiver to African American youth. This may take the shape of teen-to-teen teaching moments based on the train-the-trainer concept and create a more user-friendly name for the Waiver. //2009//

/2010/ A new project was begun as part of MAPPP: the Dual Protection Initiative. This program provides services, supplies, and referrals to reduce unintended pregnancy and STD. Co-located at a major STD clinic, immediate intervention is provided including contraceptive supplies, enrollment into the FPW, and actively managed referrals for a community-based reproductive health medical home. //2010//

Wisconsin is in the midst of dealing with a budget deficit, a declining health care work force, people in need, and negative health outcomes associated with racial disparities. Given the state

of Wisconsin's health care delivery environment, some could argue that Title V dollars are needed more today than ever before in order to fill the gaps and meet the needs where no other safety net exists.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ The State of Wisconsin projects a $6.6 billion deficit over the 2009-2011 biennium. Wisconsin's Governor has proposed that all state employees, including those who are federally-funded, will be required to take 8 days of furlough per year for a total of 16 days in the next 2 years (July 1, 2009-June 30, 2011). //2010//
An attachment is included in this section.

B. Agency Capacity

WISCONSIN STATE STATUTES RELEVANT TO TITLE V MCH/CSHCN PROGRAM AUTHORITY

The Wisconsin Legislature has given broad statutory and administrative rule authority to its state and local government to promote and protect the health of Wisconsin's citizens. In 1993 Wisconsin Act 27, created Chapters 250-255 that significantly revised public health law for Wisconsin and created an integrated network for local health departments and the state health division. In 1998, Public Health Rules HFS 139 and HFS 140 were completed to provide specific guidance concerning the statutory requirements necessary to build the capacity to protect the health of Wisconsin's residents. HFS 139 outlines the qualifications of public health professionals employed by local health departments and HFS 140 details the required services necessary for a local health department to reach a level I, II, or III designation. These important public health statutes provide the foundation and capacity to promote and protect the health of all mothers and children including CSHCN needs in Wisconsin.

Chapter 250 defines the role of the state health officials including the state health officer, chief medical officers, the public health system, the power and duties of the department, qualifications of public health nursing, public health planning, and grants for dental services.

Chapter 251 describes the establishment of local boards of health, its members, powers and duties, levels of services provided by local health departments, qualifications and duties of the local health officer, and how city and county health departments are financed.

Chapter 252 outlines the duties of local health officers regarding communicable disease to include the immunization program, tuberculosis, sexually transmitted disease, acquired immunodeficiency syndrome, blood tests for HIV, and case reporting.

Chapter 253 mandates a state maternal and child health program in the Division of Public Health to promote the reproductive health of individuals and the growth, development, health and safety of infants, children and adolescents. Chapter 253 can be found in its entirety in Appendix A. It addresses:

s. 253.06 State supplemental food program for women, infants, and children
s. 253.07 Family planning (Wisconsin Administrative Code Chapter HFS 151 describes family planning fund allocations).
s. 253.08 Pregnancy counseling services
s. 253.085 Outreach to low-income pregnant women
s. 253.09 Abortion refused; no liability; no discrimination
s. 253.10 Voluntary and informed consent for abortions

s. 253.11 Infant blindness
s. 253.115 Newborn hearing screening
s. 253.12 Birth defect prevention and surveillance system
s. 253.13 Tests for congenital disorders
s. 253.14 Sudden infant death syndrome

Chapter 254 focuses on environmental health and includes health risk assessments for lead poisoning and lead exposure prevention, screening requirements and recommendations, care for children with lead poisoning or lead exposure, lead inspections, lead hazard reduction, asbestos testing, abatement, and management, indoor air quality, radiation, and other human health hazards.

Chapter 255 addresses chronic disease and injuries and outlines cancer reporting requirements, cancer control and prevention grants, breast and cervical cancer screening programs, health screening for low-income women, tanning facilities, and the Thomas T. Melvin youth tobacco prevention and education program.

TITLE V MCH/CSHCN PROGRAM'S CAPACITY TO PROMOTE/PROTECT THE HEALTH OF MOTHERS AND CHILDREN INCLUDING CSHCN

The Division of Public Health (DPH), Bureau of Community Health Promotion (BCHP), Family Health Section (FHS) is designated as Wisconsin's Title V MCH/CSHCN Program. DPH collaborates with numerous state agencies and private organizations, LHDs, and community providers. Supported by Wisconsin's strong partnerships and sound public health law, the DPH, BCHP, FHS is well-positioned to provide prevention and primary care services for pregnant women, infants, children including CSHCN and their families that are family-centered, community-based, and culturally appropriate.

Federal grants are the primary source of funding for the majority of public health infrastructure, services and activities in Wisconsin. The amount of state General Purpose Revenue (GPR) available to support the Division's capacity for the health of the maternal and child health population, even when state mandates exist, is minimal. Thus we are in constant pursuit of additional grants to enhance our agency's capacity in the area of maternal and child health programming. In addition to the Title V Block Grant, the FHS manages 24 grants that address a range of maternal and child health related-services such as: screening and early intervention enhanced services, injury prevention and surveillance, maternal and child health services and system building including specific CSHCN activities.

/2007/ Wisconsin uses a web-based Secure Public Health Electronic Record Environment (SPHERE) for collecting data for MCH, CYSHCN, and Family Planning/ Reproductive Health. SPHERE is used to document and evaluate selected programs in Wisconsin. Public health services provided to individual clients and reported as a snapshot in time. A report based on infant assessments entered into SPHERE tells how many infants are being breastfed, how many are sleeping in the back position, which allows an agency to evaluate services that are being provided and the outcomes of those services. However, it currently does not track or report over time a comparison among those individuals. SPHERE required data is used for reporting the number of unduplicated clients served by the Title V Block Grant and some outcome data about services to those clients. Currently SPHERE is not a statewide MCH surveillance system.

SPHERE is designed as a comprehensive system to document and evaluate public health activities and interventions at the individual, household, community, and system level. The interventions include: Surveillance; Disease and other Health Event Investigation; Outreach; Case-Finding; Screening; Referral and Follow-up; Case Management; Delegated Functions; Health Teaching; Counseling; Consultation; Collaboration; Coalition Building; Community Organizing; Advocacy; Social Marketing; Policy Development; and Policy Enforcement. There are currently 1,169 active SPHERE users representing 150 organizations including all LHDs,

Regional CYSHCN Centers, private-not-for profit agencies, and the majority of the tribes. The total number of SPHERE unduplicated clients is 189,550. In 2005, SPHERE was used to document public health activities on 55,588 unduplicated clients including150,982 Individual and 8,607 Community and System Activities.

DPH collaborates with the Bureau of Health Information and Policy, Vital Records to use SPHERE to transmit confidential birth record reports to LHDs. Leveraging the existing security infrastructure of SPHERE ensured that access to birth records was restricted to only those individuals with assigned permissions and only those records for their particular jurisdiction. In 2005, a governance structure for the DPH Public Health Information Network (PHIN) was established. PHIN consolidates multiple systems into one initiative using a common set of functions. PHIN is the platform for integrated public health data in Wisconsin. In 2006, A PHIN Administrator was hired and a PHIN Lead Team was established comprised of the chair of each of the following PHIN Workgroups: 1) PHIN User Group, 2) Analysis, Visualization, and Reporting (AVR) Core Team, 3) PHIN Communications Group, 4) PHIN Security Group, and 5) Program Area Module (PAM) Integration Team. SPHERE enhancements planned for 2006-2007 include: transfer of data from WIC into SPHERE, birth record reports, testing linkage of SPHERE birth record files and newborn hearing screening, additional reports and screens to support Title V Block Grant Activities, documentation and evaluation in SPHERE for services related to the Milwaukee Home Visitation Program, Medicaid billing, and Oral Health. //2007//

/2008/ No significant change. //2008//

/2009/ The FHS manages 20 grants addressing MCH services.

SPHERE User groups were established in 5 regions, the MCH Central Office and CYSHCN Regional Centers. The statewide SPHERE lead team has been reactivated. These groups were initiated after two statewide meetings, held in 2007, identified training and SPHERE infrastructure support as system needs. A monthly WISLine web training is held. Other trainings, such as ad hoc reporting, postpartum assessment, are held monthly around the state for SPHERE public and private users. Five regional forums were held last year and are planned for fall 2008 promoting MCH systems and standards of practice. Use of SPHERE data is integrated in the presentations targeted for LHDs and MCH partners. //2009//

/2010/ 5 Regional Forums held. MCH data sheets comparing state, regional, and local data were developed and shared highlighting MCH priority areas, e.g. PNCC, Reproductive Health, Child Passenger Safety. Home Visitation Projects are piloting handheld devices using the ASQ, ASQ:SE, HOME Inventory, and Home Safety Assessment tools. Data on these tools is entered in the home on the handheld device and uploaded to SPHERE. This project will evaluate if the devices save data entry time thereby allowing more time for direct service. //2010//

STATE PROGRAM COLLABORATION WITH OTHER STATE AGENCIES AND PRIVATE ORGANIZATIONS

Approximately 60% of Wisconsin's Title V funds are released as "local aids" either as a non-competitive performance-based contract to LHDs who have "first right of refusal" or as competitive Request for Proposal (RFP) for specific, statewide or regional initiatives. Five statewide projects will begin July 1, 2005 through December 31, 2010 for services to: improve infant health and reduce disparities in infant mortality; support a genetics system of care; improve child health and prevent childhood injury and death; improve maternal health and maternal care; and create a Parent-to-Parent matching program for families with CSHCN. A new cycle for the Regional CSHCN Centers will begin January 1, 2006 through December 31, 2010 and will be aligned with the six federal core outcomes as part of the President's New Freedom Initiative. In addition, Regional CSHCN Centers will partner in the implementation of Wisconsin's new MCHB funded CSHCN Integration grant. HRSA selected Wisconsin as 1 of 7 Leadership States to help

promote the implementation of the six core components of a community-based system of services through the Medical Home concept.

/2007/ No significant change. //2007//

/2008/ Template objectives are being expanded to assure all state priorities, SPM, NPM, are addressed. Priorities for data collection and evaluation follow the same priorities. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

STATEWIDE MCH PROGRAM COLLABORATIONS

Improve Infant Health and Reduce Disparities

Beginning July 1, 2005, the statewide collaborations will focus on the following activities: 1) Support coalition building for the Healthy Babies in Wisconsin initiative, 2) Provide education on evidence-based strategies that improve infant health and reduce disparities in infant mortality, 3) Provide bereavement support services to families and others who are affected by a sudden or unexpected infant death, and 4) Establish a pilot project that supports healthcare providers and community organizations to implement strategies to reduce the risk of SIDS and infant mortality. Project activities are based on a lifespan approach, evidence-based practices identified by Perinatal Periods of Risk data model, recommendations from the Milwaukee FIMR, and core competencies identified for bereavement counseling for SIDS and infant mortality.

/2007/ In response to the worsening disparity in Wisconsin between black and white infant deaths, DHFS Secretary, Helene Nelson, named this issue as one of her top priorities and announced a strengthening of efforts to improve the maternal and child health of Wisconsin's racial/ethnic minority populations. From the announcement letter, the department has "joined with partners throughout the state to raise awareness of the racial and ethnic disparities in Wisconsin's birth outcomes. We have learned that racial and ethnic disparities are the consequences of disadvantages and inequities over an entire life course, including the increasing role that stress plays in producing poor outcomes. Intervention strategies are needed that are locally driven and community-based. Research efforts are needed that target differing risk exposures over the entire life course of a woman." The creation of a five-year Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes was announced with a focus on Communication and Outreach, Quality Improvement, Community and Evidence-Based Practices and Data.

Collaborative efforts within DHFS include those with the Medicaid program, and for mental health and substance abuse services, tobacco cessation, and teen pregnancy prevention. Future collaboration is planned through an integrative services initiative within DHFS and in cooperation with the Department of Workforce Development, with an emphasis in Milwaukee. See the website at http://dhfs.wisconsin.gov/healthybirths/ for more information.

The Infant Death Center of Wisconsin (IDC) is the grantee for the Statewide Program to Improve Infant Health and Reduce Disparities. IDC is supporting coalition building for the Healthy Babies in Wisconsin initiative and a Milwaukee Hospital Collaborative to improve perinatal outcomes. Education is provided for WIC, Prenatal Care Coordination (PNCC), and others on the revised recommendations of the American Academy of Pediatrics to reduce the risk of SIDS. Bereavement support services include counseling, memorials programs, a family conference, peer parent support, support groups, written information in newsletters and on the web page, and referral to community resources including local health departments. Targeted efforts in the city of Beloit support a community coalition to increase awareness of disparities and provide education and support to African American families with a Community Health Fair and development of a

Pregnant Women's Wish List to encourage social support. //2007//

/2008/ IDC supported coalitions to host a grand rounds presentation, Creating Smoke Free Environments, and implement Cribs for Kids program. In 2007, the Healthy Babies coalition is collaborating with the March of Dimes and the Association of Women's Health, Obstetric and Neonatal Nurses to plan and sponsor a Prematurity Summit. Education topics focus on preconception health and safe infant sleep practices. In addition to the project in Beloit, a second local coalition was established in the city of Racine.

The 2006 Progress Report on the Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes has been completed and a Statewide Advisory Committee and workgroups have been formed. Please see www.dhfs.wisconsin.gov/healthybirths for updated information on this initiative. //2008//

/2009/ IDC collaborated with community groups to produce preconception brochures. In collaboration with AWHONN and DPH, IDC is planning a preconception/prematurity conference. Curricula were developed for middle school students on Safe sleep and preconceptual health. Through the African American Mother's Wish List, social awareness on supporting pregnant women was increased in Racine, Milwaukee, Kenosha, Dane and Rock counties. The Healthy Natives Babies Consortium was formed to distribute culturally appropriate safe sleep messages.

A revised Framework for Action will be completed in the Summer of 2008. The Statewide Advisory Committee and workgroups continue to meet and are drafting recommendations for DHFS. Collaborative efforts are underway with the University of Wisconsin School of Medicine and Public Health on a Special Funding Initiative to eliminate racial and ethnic disparities in birth outcomes. //2009//

/2010/ The preconception/prematurity conference will be held in October. Middle school curricula is being reviewed by DPI. Healthy Native Baby Consortium distributed series of 5 educational cards on safe sleep. IDC collaborated with local coalitions to recruit for ABCs for Healthy Babies focus groups in Beloit, Kenosha, Racine and Milwaukee. //2010//

Statewide Genetics System

Beginning July 1, 2005, the new Statewide Genetics System will focus on the following priorities: 1) Establish a genetics advisory committee, 2) conduct comprehensive genetics needs assessment activities, 3) form a genetics specialty care providers network, 4) provide genetics education for providers and consumers, and 5) provide direct clinical genetics services to underserved populations. Project activities are based on recommendations made in the Genetic Services Plan for Wisconsin.

/2007/ In July 2005, through a competitive grants process, the Medical College of Wisconsin (MCW) (Dr. William Rhead - Principle Investigator) was selected as the vendor for the Statewide Genetics Systems grant. MCW in turn contracts with the UW-Department of Medical Genetics and the Marshfield Hospital and Clinics to meet the priorities as listed above. The Statewide Genetics Coordinator position funded by the Congenital Disorders Program will take lead responsibility for monitoring implementation of the Wisconsin Genetics Services Plan. With reductions in Title V funding, beginning in 2005 the Teratogen and Stillbirth projects are funded in part by the Wisconsin Birth Defects Prevention and Surveillance Program. //2007//

/2008/ In 2006, MCW established the Wisconsin Genetics Advisory Committee to implement recommendations of the "Genetic Services Plan for Wisconsin." Work groups were established to focus on specific priorities and needs. Through Title V funding, MCW and its partners have: provided genetics services through nine outreach clinics for underserved populations, provided clinical services through telemedicine technology, initiated educational programs among primary care medical providers, and promoted the use of genetics services in Wisconsin. //2008//

/2009/ In 2007, MCW partnered with the Statewide Genetics Coordinator to complete a needs assessment of clinical genetic services in Wisconsin. Recommendations were made to the Wisconsin Genetics Advisory Council in 2008 to address the shortage of genetic service providers, a lack of funding for genetic services, access to services by underserved populations, and education of primary care providers. //2009//

/2010/ Because of economic downturn in late 2008, Statewide Genetics Coordinator position remained vacant after incumbent left. The consideration of licensure for genetics counselors was stopped because payors felt it might contribute to increased health care costs. State Health Officer reappointed members to Genetics Advisory Council. Outreach genetics clinics continued to be held throughout state. Newborn Screening Program became first in country to screen for Severe Combined Immune Deficiency. WI was active in Region 4 seven state genetics consortium. //2010//

Improve Child Health and Prevent Childhood Injury and Death

Beginning July 1, 2005, the new statewide collaboration will focus on a statewide system to improve child health and prevent childhood injury and death. This focus relates directly to the State Health Plan, Healthiest Wisconsin 2010, and the Governor's KidsFirst agenda. The program supports all three of the overarching Healthiest Wisconsin 2010 goals (eliminate health disparities, promote and protect health for all, transform the public health system). It specifically supports system priorities for community health improvement processes and coordination of state and local public health system partnerships, and intentional and unintentional injuries and violence. The program promotes the Safe Kids, Strong Families, and Healthy Kids components of Governor Doyle's plan to improve the lives of Wisconsin children, specifically supporting reduction of family violence, ensuring safe routes to school, promoting child transportation safety, connecting families with support services, and improving the child support system.

/2007/ The Children's Health Alliance of Wisconsin (CHAW) is the grantee for this Title V MCH program. CHAW is creating a Statewide Injury Prevention Network that will include intentional and unintentional injuries. A website is being developed that will provide a collection of resources, information on prevention strategies, best practice, and a venue to share information between programs. A Summit on Childhood Injury Prevention is planned for October 2006. CHAW is collaborating with the Injury Research Center (IRC) at the Medical College of Wisconsin and the DHFS Injury Prevention Program, to create a Burden of Injury in Wisconsin Report that will include childhood information.

CHAW is partnering with DHFS and the Department of Justice (DOJ) on Child Death Review (CDR) in Wisconsin. They are looking at existing CDR teams and how they function, exploring other communities' interest in CDR and look to develop a model to support new teams. CHAW is taking the lead in the planning of a statewide training for CDR in the spring of 2007. //2007//

/2008/ In 2006, CHAW established the web-based Childhood Injury Prevention Network (CIPN), located on their website: www.chawisconsin.org. The announcement and kick-off was held at an Injury Prevention Summit in October 2006. To date, there are 300 participants on the CIPN email list. CHAW worked collaboratively with the DHFS Injury Prevention Program and the Injury Research Center-Medical College of Wisconsin to complete the "Burden of Injury in Wisconsin," which was unveiled at the Summit. The CIPN developed a preliminary strategic plan that will guide and drive the ongoing development and functions of the network. Two pilot Child Death Review Teams were established in Outagamie and Rock Counties. CHAW worked closely with the State Child Fatality Review Team, the Maternal Child Health National Center for Child Death Review and the Michigan CDR Team, to create the "Child Death Review Wisconsin Guide." This guide will be used by new child death review teams as they begin to form and review child deaths. //2008//

/2009/ During 2007, two trainings were held to support formation of local CDR teams in Wisconsin. A Partnership Grant from the UW School of Medicine and Public Health was awarded to CHAW to support local team development and mini grants of $5000 will be awarded. The State Title V MCH program funded CDR model program development in 3 counties as part of 2008 performance-based contract and its statewide CDR and Childhood Injury Prevention Network activities. Expansion of CDR teams across the state will continue. In collaboration with the Injury Prevention Program, CHAW assisted in the development and dissemination of the WI Burden of Injury Report. //2009//

/2010/ MCH program funded CDR model program development in 7 County Health Departments as part of 2009 performance-based contracts and continued to support CHAW's work with statewide CDR and Childhood Injury Prevention Network activities. In conjunction with IVPP staff and staff from the IRC at MCW, 2 trainings were held to assist local teams in using CDR data for prevention efforts. Approximately 19 teams are functioning in WI to date. //2010//

Improve Maternal Health and Maternal Care

Beginning July 1, 2005, the new statewide activities will be to: 1) Provide supportive services for the State of Wisconsin Maternal Mortality Review Program, 2) Provide education on evidence-based practices that improves maternal health and maternal care, 3) Promote preconception services for women of reproductive age, and 4) Establish a pilot project that supports healthcare providers to increase risk assessment and follow-up services for women during the preconception, prenatal and interconceptional periods. Project activities are based on a lifespan approach, evidence-based practices identified by the Perinatal Periods of Risk data model, and recommendations from the Milwaukee Fetal Infant Mortality Review.

The DPH implemented the Maternal Mortality Review Program in 2001 to assess, reduce, and prevent pregnancy-associated death among women in Wisconsin by identifying women who died during pregnancy or within one year of termination of pregnancy. Data abstraction is conducted regarding individual and clinical risks, health care utilization, and community services. Case-specific data is summarized and presented to a multi-disciplinary team for a systematic review of important contributing factors amenable to modification or prevention. Through a team process, recommendations are made for policies, services, and programs to improve maternal survival. The work of the Case Review Team was published in the Wisconsin Medical Journal. Pregnancy-related deaths in Wisconsin are generally similar to those of the US population overall and recommendations include: addressing racial disparities, assuring the performance of autopsies, lifestyle changes related to obesity and smoking, and management of embolic and cardiovascular disease, as well as postpartum hemorrhage.

/2007/ The Wisconsin Association for Perinatal Care (WAPC) is the grantee for the Statewide Program to Improve Maternal Health and Maternal Care. WAPC provides education via an annual conference, presentations at other statewide and regional conferences, written materials (position statements, newsletters, resources related to perinatal depression, guidelines for Laboratory Testing in Pregnancy), and web-based learning modules. Strategies to promote preconception services include revising the Becoming a Parent checklist and promotion of folic acid. A pilot project is supporting a health system in the city of Racine to implement postpartum depression screening for mothers in pediatric clinics. WAPC assists with the State of Wisconsin Maternal Mortality Review Program. //2007//

/2008/ WAPC supported the Perinatal Foundation's media campaign, Madre, Hay Esperanza (Mother, There is Hope) for educating Latino families about postpartum depression. Preconception resources include a new Prescription for a Healthy Future™ tool, Becoming a Parent materials, and a revised folic acid position statement. The 2006 pilot project supported a health system in the city of Racine to implement postpartum depression screening for mothers in pediatricians' offices. In 2007, healthcare providers in communities with high rates of disparities in

birth outcomes will receive a toolkit of strategies to increase screening and follow-up care for the perinatal risk factors of depression and infections.

The State of Wisconsin Maternal Mortality Review Program is planning a report of Pregnancy-Related Mortality in Wisconsin, 2002-2005. WAPC has provided professional education related to recommendations from the case review process including management of hemorrhage, management of depression, care of the obese pregnant women, preconception care, and assessment for domestic violence. //2008//

/2009/ WAPC presented the media campaign on raising awareness of perinatal depression for Latino families at 2 national and 3 statewide conferences. In collaboration with WI ACOG, WAPC developed an algorithm and medication chart for the use of antidepressants during pregnancy. The Healthy Birth Toolkit was developed to promote preconception care. A report for the PeriData.Net data system will allow birth hospitals to monitor disparities in birth outcomes.

In collaboration with the State of Wisconsin Maternal Mortality Review Program, WAPC completed a report on Maternal Mortality in WI 1998-2005. Leading causes of death include embolism, hemorrhage, cardiovascular disease and pregnancy-induced hypertension. The report addresses suicide, maternal morbidity, maternal obesity, preconception care and racial disparities. //2009//

/2010/ WAPC presented algorithm chart developed in collaboration with ACOG on the management of perinatal mood disorders during pregnancy and while breastfeeding at 2 statewide conferences. WAPC developed preconception materials on obesity for the consumer and offered education to providers. Education on use of PeriData.Net disparities report was offered. The Maternal Mortality Review Program report was disseminated to providers. //2010//

Improve Parent Support Opportunities for Families with CSHCN

Wisconsin's CYSHCN Program provides parent support opportunities for families through the five Regional CYSHCN Centers, Parent to Parent and Family Voices. The Regional CSHCN Centers assure all families of CSHCN have access to parent support services. As reported for 2006 in SPHERE, centers referred 68 parents to support groups, provided informal parent matching, referred parents to Parent to Parent and linked with local parent partners including Family Voices to determine and disseminate parent support opportunities. Parent-to-Parent of Wisconsin continues to be funded to provide one-to-one matching for families, train support parents, and seek referrals for new parents who want to be matched. Family Voices works with the CYSHCN Program to disseminate parent support information to parents through a listserv and mailings. Family Voices conducts trainings for parents to enhance their decision making skills and a parent support component is incorporated into these trainings.

/2008/ By December 2006 there were 162 families in the Parent-to-Parent database and 165 trained parents with additional trainings occurring throughout 2007. Parent-to-Parent of Wisconsin has outreached to providers including those providing services to children newly identified by the Congenital Disorders Program. In January 2007 Family Voices of Wisconsin was again funded as a Title V statewide initiative to support parent connections and related initiatives. While the regional centers continue to refer families to Parent-to-Parent and link them to support opportunities, Family Voices of Wisconsin provides broad statewide leadership to this effort. //2008//

/2009/ By December 2007 there were 190 trained support parents in the Parent-to-Parent database and 78 matches. Parent-to-Parent of Wisconsin translated their curriculum into Spanish, trained non-English speaking support parents and is matching hard-to-reach families in Milwaukee. Family Voices of Wisconsin is funded to build a parent network of informed decision makers, through training, information dissemination and analysis of unmet needs. //2009//

/2010/ By 12/31/08 there were 86 parent matches made by Parent-to-Parent. Number of trained support parents in P2PWI database is now 214. Three trainings were conducted in 2008, including one focusing on Latino families in Milwaukee for a partnership with Latino organization, Alianza Latina Aplicando Soluciones. P2PWI maintains listserv for support parents and will implement an electronic parent chat room in 2009 hosted on their new website (p2pwi.org). //2010//

Regional CYSHCN Program Collaborations

The goals of the Regional CYSHCN Centers are to:
• Provide a system of information, referral, and follow-up services so all families of children with special health care needs and providers have access to complete and accurate information.
• Promote a Parent-to-Parent support network to assure all families have access to parent support services and health benefits counseling.
• Increase the capacity of LHDs and other local agencies, such as schools, to provide service coordination.
• Work to establish a network of community providers of local service coordination.
• Initiate formal working relationships with LHDs and establish linkages for improving access to local service coordination.

Each Regional CYSHCN Center has distinct characteristics (located in regional hospital, children's hospital, academic training center, local health department, and family resource center) that collectively present a variety of viewpoints and areas of interest and influence. Currently, Title V block grant dollars are provided to local agencies in nearly every county through contracts with the Regional CYSHCN Centers. The Regional CYSHCN Centers have established a network of active partner parents, many of whom are directly connected to the local health department or other community agency.

The Regional CYSHCN Center model will continuously be refined and focus on the 6 core (national) outcomes.

/2008/ Five Regional CYSHCN Centers are in the second year of a five year grant cycle. Core services continue to be information, referral, and follow-up including health benefits services for families and providers. In this grant cycle, there is an increased emphasis on the six NPMs and strengthening CYSHCN collaborations. Regional Centers are actively fostering collaboration with key partners including: cross-referral discussions with Children's Long-Term Care Redesign pilot site; sharing resources with Early Childhood Collaborating Partners (including ECCS); facilitating the spread of Medical Home to local medical practices through the administration of Medical Home Local Capacity Grants and direct team facilitation; offering families with children registered with the Wisconsin Birth Defects Prevention and Surveillance program referral and follow-up services; and cross-referring with WIC nutritionists. While centers continue to provide support to youth and families, parent leadership and support activities are now shared with the statewide Parent-to-Parent of Wisconsin and Family Voices of Wisconsin grants. //2008//

/2009/ No significant change. //2009//

/2010/ The Collaborators Network continues to expand to include not only the CYSHCN Centers, GLITC, FVW, Parent-to-Parent but also the WIC-CYSHCN Network and MCHB funded CYSHCN Oral Health Project. //2010//

Statewide MCH Hotline

Gundersen Lutheran Medical Center-LaCrosse provides services for the Public Health Information and Referral Services for Women, Children and Families (hotline) contract. The contract supports services for three different hotlines that address a variety of MCH issues to

include: Healthy Start, Prenatal Care Coordination (PNCC), WIC, family planning, and women's health issues. One hotline, Wisconsin First Step, is specifically dedicated to supporting the needs of the Birth to 3 Program, the Regional CSHCN Centers, and providing information and referral services to individuals, families, or professionals needing to find resources for CSHCN.

In 2004 the MCH Hotline received 8,549 calls; an increase of 516 calls from 2003. Just over 3% of the calls required Spanish translation. The Wisconsin First Step (WFS) Hotline received 2,103 calls in 2004; an increase of 604 calls from 2003. In addition to the toll-free hotlines, the website www.mch-hotlines.org has become a well-utilized resource. In 2004 the website received approximately 35,000 hits to the entire site. A searchable database feature was added to the website in 2003. In addition, in 2004 a pregnancy assessment tool and a user feedback form were added to the website and work has begun to translate the website pages in Spanish.

/2007/ The MCH Hotline received 9,025 calls in 2005; an increase of 476 calls from 2004. Approximately 4% of the calls required Spanish translation. The Wisconsin First Step Hotline received 2,185 calls in 2005; an increase of 82 calls from 2004. The website continues to be a well-utilized resource, receiving approximately 37,000 hits to the entire site in 2005. Strategies were evaluated to reach the following priority population callers: Spanish speaking, at risk pregnant women, and homeless individuals and families. This evaluation showed an increase in Spanish speaking callers and callers who were pregnant. The report showed an increase in the number of Prenatal Care Coordination, WIC, Food Share, and Presumptive Eligibility referrals made to callers. 734 hits were documented to the web based pregnancy assessment tool. The homeless population continues to be a challenge to reach. //2007//

/2008/ The MCH Hotline received 11,196 calls in 2006; an increase of 2,171 from 2005. In part this increase was due to a back to school ad campaign sponsored by Covering Kids and Families of Wisconsin targeting families in Milwaukee County who may be eligible for BadgerCare. Approximately 4% of the total MCH calls required Spanish translation. The hotline has a contract with Certified Languages International. Most calls are answered in under 1 minute. One staff is bilingual. Inservices for staff have been done providing them with multiple phrases to explain to people they will be connected to the language line for translation assistance. The database provides information for services that are provided in Spanish. The WFS hotline received 2,344 calls in 2006; an increase of 159 from 2005. In 2006, additional tracking component was added to the hotlines' website search engine identifying 112,516 total page views in 2006. The top program areas searched on the website were Birth to 3, WIC, and Prenatal Care Coordination. The site now features a place to download the five regional WFS directories. In September 2006, two education days were held for staff. //2008//

/2009/ The MCH Hotline received 8,634 calls in 2007; a decrease of 2,562 calls. No calls were taken for the BadgerCare campaign and there was a change in how calls were logged (see Section IV F). Approximately 4% of the total MCH calls required Spanish translation. The WFS hotline received 1,932 calls in 2007; a decrease of 412 calls. In 2007, a new online directory was added to the website allowing users to generate WFS directories using live data from the hotline database. The top program areas searched for continue to be Birth to 3, WIC, and Prenatal Care Coordination. Results of a 4th Quarter automated survey shows 99% of 87 MCH respondents felt they had been heard/supported by the I&R Specialist and 100% for 11 WFS respondents. //2009//

/2010/ MCH Hotline received 8,477 calls in 2008; a decrease of 166 calls. Approximately 4% of these calls required Spanish translation. The WFS Hotline received 1,792 calls in 2008; a decrease of 140 calls. Marketing efforts showcased capabilities and features of the website. Training on the new website search engine was offered. Top program areas searched for are WIC, FoodShare, family support programs, and Birth to 3. Web statistics document an average of 1,317 hits per day. WFS Directory pages have been downloaded over 5,600 times. Resource House search engine results were viewed over 4,700 times. Website activity believed to be reason for decrease in hotline calls. //2010//

OTHER KEY STATE COLLABORATIONS

Reproductive Health Services

In 2004, the DHFS established a Family Planning and Reproductive Health Council. Its role is to provide advice to the Secretary and foster internal Departmental coordination to insure access to cost-effective family planning services and reproductive health care. Through this Council, collaboration among the MCH's Family Planning Program, the Wisconsin Medicaid Program (which administers the Medicaid Family Planning Waiver), and external health care providers has significantly increased. As a result of this collaboration we have seen the Family Planning Waiver become successful in Wisconsin. Through December 31, 2004, 55,515 women were enrolled; representing approximately 17% of the estimated Waiver eligible population.

/2007/ No significant changes. //2007//

/2008/ As of December 31, 2006, 62,935 women were enrolled in the Family Planning Waiver, representing approximately 22% of the estimated Waiver eligible population. Wisconsin will submit a renewal application for the Medicaid Family Planning Waiver in 2007. The Waiver has created new opportunities for collaborations, resulting in increased access to services. //2008//

/2009/ The Family Planning Waiver was renewed January 1, 2008 for 3 years. //2009//

/2010/ Implementation of FPW continued. Provisions of Deficit Reduction Act, which made the enrollment process more complicated and time consuming for otherwise eligible women, resulted in decreased enrollment. //2010//

MCH Advisory Committee

The MCH Advisory Committee consists of about 40 diverse members representing various backgrounds who come together on a quarterly basis for the purpose of advising the Division of Public Health on important maternal and child health issues as requested. The meetings provide the members with current information, encourage sharing and networking of pertinent information, and the opportunity to discuss issues related to the MCH program. Its diverse membership fosters the development of informal relationships with representative of a broad range of entities. Membership includes parents, and representatives of local health departments, nonprofit agencies, tribal agencies, and academic institutions.

In 2004, the MCH Advisory Committee identified Early Childhood Comprehensive Systems. Members were briefed on state and national ECCS efforts and activities. Committee comments were solicited on the year-one progress report and year-two plan.

/2007/ Over the past year, the MCH Program Advisory Committee has engaged in dialogue and focus group activities on mental health topical areas such as infant mental health, depression across the lifespan, and mental health in the workplace, with a goal to help infuse mental health into public health practice within the MCH/CYSHCN Program and partnerships. The MCH Program Advisory Committee will be addressing several of the policy recommendations as outlined in the Lieutenant Governor's Task Force on Women and Depression in Wisconsin Report-May 2006 www.ltgov.state.wi.us. //2007//

/2008/ Continuing the focus on mental health, the MCH Program Advisory Committee created a joint statement titled "A Foundation for Collaboration between DPH and the Division of Mental Health and Substance Abuse Services (DMHSAS)". This statement emphasizes the integration of mental, physical, social, emotional and spiritual health for all persons. In addition an "Action Guide Addressing Mental Health" was developed by MCH Advisory Committee and the state divisional staff. This guide focuses on the areas of Businesses/Workplaces Schools and Child Providers Infant-Age 18, Technical Colleges/Colleges/Universities, Communities and Other

Providers, and Strengthening State Government's Role in Developing MCH and Mental Health Linkages. The process and products were displayed via a poster session at the Wisconsin Public Health Association/Wisconsin Association of Local Health Departments and Boards Annual Meetings and both organizations have agreed to endorse the statement and to review the Action Guide to determine what specific steps they may take in the local counties. Additional plans include a wider dissemination of the Joint Statement and Action Guide as well as presentations during the 5 MCH Regional forums to be held during the spring and summer. //2008//

/2009/ The MCH Advisory Committee worked to move the Joint Statement and Action Guide from an MCH Advisory Committee document to a high level enterprise policy document within DHFS entitled "The Integration of Physical Health, Mental Health, Substance Use and Addiction". Endorsed by the DHFS Secretary and all Divisions, the Joint Statement and Action Guide provide a conceptual framework for systematic changes and call to action in our communities. This Document will move forward for endorsement by other Departments. The MCH Advisory Committee will be part of the Healthiest Wisconsin 2020 process to assure MCH objectives are outlined within the new state health plan. //2009//

/2010/ See Public Input I.E. //2010//

C. Organizational Structure

On January 6, 2003, Jim Doyle was sworn in as Wisconsin's 44th Governor. Concurrently, Barbara Lawton was sworn in as Wisconsin's first female elected Lieutenant Governor. Through her work, such as her Wisconsin Women = Prosperity initiative, she has championed women's health issues.

Prior to serving as Governor, Mr. Doyle was the state Attorney General for 12 years and known as a national leader in the fight to improve public health through his successful lawsuit against the tobacco industry. Today, Governor Doyle considers children a high priority. In order to invest in Wisconsin's future he developed an ambitious initiative known as the KidsFirst Agenda. Governor Doyle believes "that the single most important thing we can do today to ensure a strong, successful future for Wisconsin is to invest in our kids early … because what we do now will determine what kind of state Wisconsin will be 10, 20, even 50 years from now" (KidsFirst 2004). KidsFirst has four parts: Ready for Success; Safe Kids; Strong Families; and Healthy Kids. We are working to implement the Governor's KidsFirst effort which will contribute to improving the health of children by:

- Providing all children with health care coverage
- Improving oral health care
- Immunizing children on time
- Serving kids a healthy school breakfast
- Ensuring eligible families receive food stamps
- Teaching children fitness and nutrition for life
- Reducing youth smoking
- Stepping up efforts to reduce teen pregnancy
- Reducing children's exposure to lead paint
- Helping kids with asthma
- Giving infants a healthy start
- Promoting early childhood mental health

A copy of the publication can be found at www.wisgov.state.wi.us.
In July 2004, the DHFS Secretary implemented the Public Health Restructuring Plan with the purpose to focus and streamline the role of state government to: improve state agency operations and to free up resources to invest in local government and other public health partners and shift some regulatory and case specific services to the local level where they can be performed more efficiently and effectively.

Governor Doyle named Helene Nelson as the Secretary of the Department of Health and Family Services. She is an experienced executive in state and county government and served under four different governors as Deputy Secretary or Chief Operating Officer for five state agencies: Revenue; Transportation; Health and Social Services; Industry, Labor and Human Relations; and Agriculture, Trade and Consumer Protection. In April 2005, Roberta Harris was appointed as the Deputy Secretary and will serve as chief operating officer for the Department overseeing internal management on behalf of the Secretary. She is recognized as a highly effective leader in the Milwaukee community and will be sharing her time between Madison and Milwaukee focusing on the Governor's KidsFirst agenda.

There are five major divisions and two offices in the Department of Health and Family Services. Official and dated organizational charts are on file in the state office and available on request or accessible via the website at www.dhfs.state.wi.us/organization/dhfs/functions.pdf. A brief summary of each division/office follows.

The Office of Legal Counsel (OLC) is an office within DHFS which serves the Secretary and acts as a resource for the Department as a whole. The mission of OLC is to provide effective and accurate legal services and advice to the Department.

The Office of Strategic Finance (OSF) provides department wide planning, budgeting, evaluation and county/tribal liaison services.

The Division of Management and Technology (DMT) provides management support for fiscal services, audit, information technology, personnel, affirmative action and employment relations.

The Division of Children and Family Services (DCFS) focuses on issues, policies and programs affecting children and families from a social service perspective, and has the responsibility for the regulation of the child welfare programs.

The Division of Disability and Elder Services (DDES) is responsible for 1) long term support for the elderly and people with disabilities including the Birth to Three Program, 2) mental health and substance abuse services and 3) regulation and licensing.

The Division of Health Care Financing (DHCF) is responsible for administering the Medical Assistance (Medicaid), Food Share, Chronic Disease Aids, Health Insurance Risk Sharing Plan (HIRSP) and General Relief programs.

The Division of Public Health (DPH) is responsible for providing public health services, and environmental and public health regulation. The Division has programs in the areas of environmental health; occupational health; family and community health including injury prevention, emergency medical services, chronic disease prevention and health promotion; and communicable diseases. It is also responsible for issuing birth, death, marriage and divorce certificates as well as collecting statistics related to the health care industry and the health of the people in Wisconsin. Coordination and collaboration with other DHFS divisions and within DPH's bureaus is expected and regular, especially for particular programs and topic areas such as CSHCN, teen pregnancy prevention, STIs, tobacco use, child abuse prevention, etc.

On July 11, 2005, Dr. Sheri Johnson assumed the position as Division of Public Health Administrator. Dr. Johnson holds a M.A. and Ph.D. in Clinical Psychology from Boston University with clinical fellowship experience from Harvard Medical School. Her interests and experiences include trauma, HIV/AIDs, foster care, and community influences on child and adolescent development. She has conducted research on addressing racial disparities and assuring cultural competence in health care.

With the restructuring completed in July 2004, five bureaus were formed (reduced from six bureaus) within the DPH:

The Bureau of Community Health Promotion (BCHP) has a primary responsibility to provide a statewide model of integrative public health programming across the life span. The Bureau has key relationships with local health departments, community-based organizations, private voluntary organizations, and academic and health care provider networks.

The BCHP contains four organizational sections: Family Health; Nutrition and Physical Activity; Chronic Disease and Cancer Prevention; and the Tobacco Prevention Program. The BCHP has over 100 employees, doubling in size as two bureaus merged together as part of the restructuring plan.

Within the BCHP, the Family Health Section has responsibility for the Title V Program and to improve the health of women, infants, children including Children with Special Health Care Needs Program (CSHCN), teens, and families as they progress through the critical developmental milestones of life. A major emphasis of the programs within the Family Health Section involves prevention (including injury prevention and sexual assault prevention), early screening, and early intervention. Examples of the continuum include newborn screening, universal newborn hearing screening, early identification of pregnancy, and breast and cervical cancer screening. A more detailed description is found in Section D.

See Attachment for Section III. C. - Organizational Structure (Family Health Section Org Chart).

The Nutrition and Physical Activity Section has responsibility for a variety of public health nutrition education and food programs. WIC (The Special Supplemental Nutrition Program for Women, Infants and Children) and WIC FMNP (Farmers' Market Nutrition Program) provide both supplemental nutritious foods and the critical nutrition information needed for healthy growth. TEFAP (The Emergency Food Assistance Program) and CSFP (Commodity Supplemental Food Program) provide USDA commodity foods to low income families. Several nutrition education programs such as the Nutrition and Physical Activity Program, 5 A Day for Better Health, and the Food Stamp Nutrition Education Program to promote healthy eating and physical activity for good health. The Section is also responsible for addressing food insecurity and hunger.

The Chronic Disease and Cancer Prevention Section has responsibility to plan, promote, implement, and evaluate comprehensive population and evidence-based programs using best practices in the following areas: Diabetes Prevention and Control, Cardiovascular Health, Arthritis Prevention and Control, and Comprehensive Cancer Prevention and Control.

The Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. This is accomplished through programs that use best practices to prevent the initiation of smoking by youths and adults, promoting treatment for persons with tobacco-related addictions, and protecting all residents from exposure to environmental smoke.

The Bureau of Communicable Diseases and Preparedness is responsible for the prevention and control of communicable diseases in Wisconsin and for ensuring that the public health and hospital systems are fully prepared for bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

The Bureau of Environmental and Occupational Health promotes public health through statewide programs to increase public awareness of environmental and occupational health hazards and disease and works to prevent and control exposure to environmental and occupational health hazards.

The Bureau of Health Information and Policy's primary responsibilities are to: collect, maintain and provide vital records for the citizens of the state; integrate and manage major public health related information systems; collect, protect, disseminate and analyze health care and population-based health data needed to conduct critical state business; and support a division-wide planning

and policy focus on population health that will result in achieving the goals set out in the state health plan, Healthiest Wisconsin 2010.

The Bureau of Local Health Support and Emergency Medical Services has a primary responsibility to build partnerships and to provide leadership and support through the development and recommendations of statewide policy related to the Wisconsin Public Health System and emergency medical services community.

The Regional Offices of the Division of Public Health primarily function as information pipelines through which central office and local health departments communicate.

/2007/ The FHS no longer has responsibility for the breast and cervical cancer screening program known as WWWP but remains within our Bureau. //2007//

/2008/ In November 2006, Jim Doyle was reelected and in January 2007 sworn in as the 45th Governor of Wisconsin. Concurrently Barbara Lawton continues as Lt. Governor. Through her ongoing work, such as the Lt. Governor's Task Force on Women and Depression in Wisconsin Report, May 2006 (http://www.ltgov.state.wi.us), she continues to champion women's health issues which have strengthened MCH's collaboration with Mental Health.

Secretary Helene Nelson retired from the DHFS in November 2006. Kevin Hayden, Division of Health Care Finance Administrator at DHFS was appointed as the new DHFS Secretary effective January 2007.

In April 2007, the Division of Disability and Elder Services was separated creating the Division of Mental Health and Substance Abuse Services, the Division of Long Term Care, and the Division of Quality Assurance. Further DHFS changes included restructuring and renaming the Division of Management and Technology and the Office of Strategic Finance. The Division of Management and Technology is renamed the Division of Enterprise Services, and the Office of Strategic Finance is renamed the Office of Policy Initiatives and Budget. //2008//

/2009/ In April 2008, Secretary Hayden stepped down to return to the private sector. Karen Timberlake was appointed as new Secretary for DHFS. On June 6, 2008, Dr. Sheri Johnson, DPH Administrator left her post. Tom Sieger, Deputy DPH Administrator will be interim Division Administrator until her position is filled. As of July 1, 2008 DHFS will be split into two departments--Department of Children and Families (Reggie Bicha, Secretary) and Department of Health Services (Karen Timberlake, Secretary). The MCH Program will remain within the Department of Health Services, with the exception of one position that was responsible for monitoring the Home Visitation Programs of Family Foundations and Empowering Families of Milwaukee. The position, but no MCH funding, will be going to the Department of Children and Families. There will be five Divisions in the new Department of Health Services: Divisions of Public Health, Long Term Care, Mental Health and Substance Abuse, Quality Assurance, and Medicaid. //2009//

/2010/ Medicaid Division within DHS changed its name to the Division of Health Care Access and Accountability with formation of new department. January 19, 2009 Dr. Seth Foldy was appointed as new Division of Public Health Administrator. Dr. Foldy was Commissioner of Health, Milwaukee County two years prior to his appointment and had been working on eHealth and incident command related projects prior to his appointment. The State's budget has a deficit. Hiring freezes are in place and all state employees will be furloughed a total of 16 days over the biennium. The Division of Public Health is undergoing a reorganization, but there will be minimal impact on the Family Health Section / Maternal and Child Health Programs. Healthiest Wisconsin 2020 is being worked on with involvement of MCH staff and their external partners. 2010 MCH Needs Assessment is underway and planned to be completed by December to be included in 2011 MCH Block grant application, July 2010. //2010//

An attachment is included in this section.

D. Other MCH Capacity

/2007/ Wisconsin's current Title V MCH Block Grant award is $10,919,759. This is Wisconsin's smallest grant award since 1993! Beginning in 1995, the Wisconsin's Title V MCH Block Grant award has steadily declined (except for slight increases in 1999, 2000 and 2002 of 1 - 2%). In 2004, we experienced our biggest Title V cut EVER of 5.44% ($-648,146) with another significant cut in 2006 of 2.67% ($-299,935). To address the MCH budget reductions, the Department cut state operations by 19% by 2007. During SFY 05, Title V MCH Block Grant supported 46.99 FTEs. For SFY 07, the Grant supports a total of 37.04 FTEs. We have eliminated 9.95 FTEs, but the workload and needs continue. Following is an update of positions that are authorized and funded, respectively, by Wisconsin's Title V MCH Block Grant.

On May 1, 2006, the BCHP implemented a minor organizational realignment. The BCHP Office has nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds. (The first number represents the position authority and the number in ( ) represents the amount that is charged to Title V funds.) The Bureau Office consists of the: Bureau Director 1.0 FTE (.25 charged to Title V) Susan Uttech; Chief Medical Officer 1.0 FTE (.75) Murray Katcher; Chief Dental Officer 1.0 FTE (1.0) Warren LeMay ; CYSHCN Medical Director .75 FTE (.75) Sharon Fleischfresser; Health Education Specialist .80 FTE (.80) Mary Gothard; Program Director for Disparities in Birth Outcomes 1.0 FTE (1.0) Patrice Onheiber; State Dental Hygienist Officer 1.0 FTE (1.0) Vacant; and Bureau Office Manager .45 FTE (.45) Debbie Hess. In addition, the Youth Policy Director, Claude Gilmore, is located in the BCHP Office but the position authority and funding support is from CDC's Comprehensive School Health Program.

The Family Health Section (office) consists of fourteen staff of which 6.0 FTE are supported with Title V MCH Block Grant funds: Family Health Section Chief 1.0 FTE (1.0) Linda Hale; MCH Unit Supervisor 1.0 (1.0) Vacant; Grants Coordinator 1.0 FTE (1.0) Jayne McCredie; Office Assistant 1.0 FTE (1.0) April Spores; SPHERE Data Consultant 1.0 FTE (1.0) Susan Kratz; and Injury Prevention Consultant 1.0 FTE (1.0) Vacant. The other FHS positions include: SSDI, Organ and Tissue Donor, EMSC, Sexual Assault Prevention, Injury Surveillance, and three contracted positions for Injury, Congenital Disorders, and Genetics.

The MCH Unit (which includes the CYSHCN Program) has 17 staff of which 11.0 FTE are supported with Title V MCH Block Grant funds to include: 4.0 FTE Public Health Nurses who address: maternal and perinatal health; infant and young child health; child health; adolescent health; and children and youth with special health care needs; 3.0 FTE Public Health Educators who address: women's health, reproductive health and family planning; school-age and adolescent health, and children and youth with special health care needs; 2.0 FTE Epidemiologists (one who is dedicated to the MCH Program and one who is dedicated to the CYSHCN Program) 1.0 FTE Audiologist; and 1.0 FTE Office Assistant. The remaining MCH Unit staff include: the Abstinence Consultant, ECCS Coordinator, WE-TRAC Project Manager, and two CYSHCN contracted positions.

The remaining 13.04 FTEs funded with Title V funds within DPH are:
- .32 FTE publications coordinator in the Nutrition and Physical Activity Section
- .70 FTE Lead Prevention Consultant in the Bureau of Environmental and Occupational Health
- 1.1 FTE Fiscal Grants Managers in the Office of Operations
- 1.0 FTE Policy Coordinator in the Bureau of Health Information and Policy
- 9.92 FTE that provides partial infrastructure support for staff time of regional office directors, nurse consultants, health educators, and nutritionists. //2007//

/2008/ Wisconsin's current Title V MCH Block Grant award is $10,919,759. For SFY 08, the Grant continues to support a total of 37.04 FTEs. Following is an update of positions that are authorized and funded, respectively, by Wisconsin's Title V MCH Block Grant.

The 13.04 FTEs funded with Title V funds within DPH remain the same. There are 9 vacant positions, 5 that are MCH funded within the Family Health Section. All five are in process of being filled with the intent to have this accomplished by mid November.

The BCHP Office continues to have nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds. The only change from SFY 2007 is that Lisa Bell was hired as the State Dental Hygienist Officer filling the 1.0 FTE vacancy in March 2007.

The Family Health Section (office) consists of 18 staff which 7.0 FTE are supported at some level with Title V MCH Block grant funds. The 1.0 FTE MCH Unit Supervisor vacancy was filled by Terry Kruse in November 2006.

The MCH Unit (which includes the CYSHCN Program) continues to have 13 staff of which 10.0 FTEs are supported with Title V MCH Block Grant funds. The MCH Unit Abstinence Consultant position (1.0 FTE) not funded by the Title V MCH Block Grant has been vacant since February 2007. This position will not be filled because Wisconsin has decided to not accept future federal abstinence funds. This decision was related to the changes that have occurred over time. We have accepted federal abstinence education funds every year since 1997. In the past, grantees were allowed to implement select elements of the abstinence program. Now grantees must strictly adhere to all eight elements in the definition of abstinence education specified in Title V of the Social Security Act. If federal requirements are modified in the future, the State would reconsider an application for abstinence education funds. //2008//

/2009/ Wisconsin's current Title V MCH Block Grant award has been cut by $120,872 and is now $10,800,119.

For SFY09, the Grant supports 36.14 FTE (down 1 FTE in the MCH Unit due to Home Visiting Program going to new Department; no Title V monies will be going with the position).

Within DPH, the same 13.14 FTES from 2008 are funded through Title V funds.

A total of 10.02 FTEs support the work done in the five health regions. This is an increase of .1 (from 13.04 in 2007-2008 to 13.14 in 2008-2009) will be going to the Western Regional Office to assist in the support of the CYSHCN Nutrition Network activities.

The BCHP Office has nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds.

There are a total of 16 FTEs between the Family Health Section office (6.0) and MCH Unit (was 11 but now is 10 because of the development of the new Department of Children and Families).

There is currently one vacant position within the Family Health Section, Program Support/Human Services Coordinator. Due to the cut in the block grant funding, it is the program's intent to not fill this position at this time. //2009//

/2010/ Wisconsin's current Title V MCH Block Grant award is $10,824,984. Position authority for MCH Program Support/Human Services Coordinator was eliminated. All positions are filled; thus, the SFY 10 grant is supporting 35.14 FTE. The 35.14 FTEs remain as described in 2009. //2010//

E. State Agency Coordination

E. State Agency Coordination
COORDINATION OF TITLE V MCH/CYSHCN PROGRAM WITH EPSDT, WIC, TITLE XIX, AND BIRTH TO 3

Prenatal Care Coordination (PNCC)

Title V supports Medicaid PNCC to help pregnant women gain access to medical, social, educational, and other services related to pregnancy. Services are available to Medicaid-eligible pregnant women, at risk for adverse pregnancy outcomes, through 60 days following delivery.

Many PNCC providers participate in the First Breath Program of WI Women's Health Foundation (WWHF). First Breath provides education, support, and resources to help pregnant women quit smoking. Some LHDs use Title V funds to provide like services to women who not eligible for PNCC.

/2007/ A new PNCC assessment tool was implemented. Training was provided on the new tool, PNCC data, SPHERE, and outcomes including perinatal depression, spacing pregnancies, and safe infant sleep. The My Baby and Me program was piloted with PNCC providers to address alcohol use of pregnant women. MCH helped DHFS evaluate the Medicaid PNCC benefit. //2007//

/2008/ Collaboration with My Baby and Me occurred at a fall statewide family planning meeting about preconceptional counseling and screening for substance use. A national curriculum, Great Beginnings Start Before Birth (GBSBB), was identified to promote strategies for psychosocial support and to engage and retain clients. Other web casts are available. Activities to implement outcomes for PNCC using regional provider groups were: data collection on key outcomes, identifying benchmarks, and sharing successful improvement efforts.

Women's Health Now and Beyond Pregnancy pilot focuses postpartum services on interconception services: distributing emergency contraception and dual protection supplies; assuring access to continuing family planning supplies and services; assuring enrollment in the Family Planning Waiver or other Medicaid; distributing multivitamins containing folic acid; and promoting women's health. //2008//

/2009/ Research thesis reported reductions in LBW, VLBW, preterm birth and NICU admissions for infants of women receiving PNCC. The MCH program offered PNCC trainings at northern LHD and tribal sites. Regional PNCC provider groups offer education on best practices and desired outcomes. GBSBB training was offered and other trainings are planned. Women's Health Now and Beyond Pregnancy pilot was implemented by 5 PNCC programs. //2009//

/2010/ LHDs offered 5 regional GBSBB training and 2 PNCC provider trainings. Women's Health Now and Beyond Pregnancy pilot was presented at national/state conferences and is being integrated into Reproductive Health template objectives. MCH is collaborating with Medicaid to revise PNCC handbook and provider requirements. //2010//

Birth to 3 Program

The Part C early intervention program, Birth to 3 (B-3), is located in the DDES Children's Services Section that also administers the Children's Long-Term Care redesign, waiver programs, and Family Support. CYSHCN works with DDES. WI Sound Beginnings has integrated Early Hearing Detection and Intervention (EHDI) programming with B-3 services. MCHB funds are given to the B-3 Program to improve services for children who are deaf and hard of hearing. CYSHCN/ B-3 developed and implemented the use of a nutrition screening tool to promote early identification of nutrition needs. Joint surveys and communication are developed to inform health care providers about Part C and Title V services. CYSHCN and B-3 pooled resources to fund First Step, a 24/7 toll free hotline (includes TTY and language line) and website for parents and providers of CYSHCN. Per statute, B-3 staff is appointed by the DHFS Secretary to serve on the Birth Defect Prevention and Surveillance Council.

CYSHCN staff is on the State's B-3 Interagency Coordinating Council (ICC), Children's Long-Term Care Committee and B-3 Autism Services workgroup on policies and practice standards. CYSHCN staff co-leads the annual Circles of Life Conference for families of CYSHCN with B-3 Staff.

/2007/ The Birth Defect Prevention and Surveillance Council provide input to B-3 on Eligibility and Diagnosed Conditions and Atypical Development document. //2007//

/2008/ No significant change. //2008//

/2009/ CYSHCN staff and contracted partners attend B-3 regional forums and in-services to provide updates and encourage referrals. //2009//

/2010/ CYSHCN Program Medical Director chairs newly formed ICC Child Find Committee. With B-3, CYSHCN Program is conducting regional ASQ trainings for primary care providers. B-3 staff participate on EHDI Learning Collaborative QI teams and Steering Committee for Connections autism grant. //2010//

HealthCheck -WI's Early and Periodic Screening, Diagnosis and Treatment Program

HealthCheck promotes early detection and treatment of health conditions associated with chronic illness and disabilities in children. Health exam for children include growth, development, hearing and vision checks, immunizations, and a complete physical exam. Since 1992, exams have increased from 27% to 71% because of the Medicaid Managed Care program. WI Medicaid data has shown children in HMOs are more likely to receive a HealthCheck exam than children in fee-for-service systems.

/2007/ In 2005, 337,533 health exams were performed; the exam rate increased to 86%. In October 2005, a HealthCheck Statewide Training was held with 150 attendees. //2007//

/2008/ In 2006, 352,884 health exams were performed; the exam rate increased to 88%. //2008//

/2009/ In 2007, 359,491 health exams were performed; an exam rate of 88%. //2009//

/2010/ With new computer system, updated exam data is unavailable. //2010//

Coordination with Family Leadership and Support

MCH partners with Family Leadership and Support Programs/Initiatives to develop plan and implement activities for families. Coordination occurs with parent organizations such as WI Family Voices, WI Family Ties, FACETS, Parents as Leaders and Parents in Partnership Training Initiative, Family Action Network and the Parent-to-Parent Matching Program.

/2007/ In 2006 CYSHCN support was given to the Circles of Life Conference for families of children with disabilities. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ FVW and their partners held an advocacy parent leadership institute. FVW and Survival coalition are developing 09-11 biennial budget priorities. //2010//

Relationship with Mental Health

The Injury Prevention Program (IPP) works closely with the BMHSA, Mental Health Association of

Milwaukee County, and county and local mental health professionals on suicide prevention across the life span. The IPP leads monthly meetings of the Suicide Prevention Initiative (SPI).

An Internal MH/AODA Coordination Committee formed in February 2005 and is co-chaired by the Director of BMHSA and DHFS Youth Policy Director with members from education, public health, and mental health/substance abuse divisions. The purpose is to improve inter-divisional and interdepartmental communication and coordination.

In 2005, MCH established a State Bullying Prevention Planning Committee. Members are from public education, public health, medical schools, media, and local community agencies. Activities include public awareness campaign, listing of current best practices, establishing statewide network information sharing, exploration of policy and legislation strategies, and link to the Healthiest WI 2010 State Health Plan.

/2007/ The SPI works with the statewide Crisis Network comprised of county crisis teams. SPI representatives attend the network's quarterly meetings. IPP staff participates on the planning of the DHFS Crisis Conference.

The MCH Program Advisory Committee held discussions of infant mental health, depression across the lifespan, and mental health in the workplace, with a goal to help infuse mental health into public health practice within Title V Program and partnerships. The Committee will address policy recommendations in the Lieutenant Governor's Task Force on Women and Depression in WI Report-May 2006 www.ltgov.state.wi.us.

The CYSHCN Health Promotion Consultant participates in a DPI workgroup on school curriculum for middle school children with mental health disorders; part of the anti-stigma objective from the WI United for Mental Health initiative. The curriculum complements the Suicide Prevention Curriculum. //2007//

/2008/ Working with the DMHSA, MCH staff serve on mental health workgroups: WI United for Mental Health; Workgroup to establish a crosswalk and billing system for Medicaid infant mental health service providers; Inter-Intra-Departmental Adolescent Treatment Focus Group; Seclusion and Restraint Workgroup; Children and Youth Sub-Committee of the Mental Health Council; Mental Health in Primary Care; Infant Mental Health workgroup; and the WI Infant and Early Childhood Mental Health Steering Committee. CYSHCN Regional Centers' Medical Home systems change grants is focusing on children with mental health issues. SPI continues with involvement from the MCH program, IPP, DMHSA, DPI, HOPES (Helping Others Prevent and Educate about Suicide), Mental Health Association of Milwaukee, and Department of Corrections. //2008//

/2009/ The Integration of Physical Health, Mental Health, Substance Use, and Addiction Initiative will be launched in 2008. The Infant Mental Health Steering Committee produced the 2007 Annual Report and Fact Sheet for the Leadership Team and Governor's Office. The Division of Mental Health has engaged all DHS Divisions in a mental health transformation initiative using Pubic Health principles and processes with a goal to eliminate seclusion and restraint for children in day treatment settings, group homes, out-of-home placement, and foster care settings. CYSHCN staff provides consultation. WI United for Mental Health received a Healthier WI Partnership Grant to address mental health stigma in minority populations. LHDs recruit minority women for focus groups to get information about stigma within their environment and culture. //2009//

/2010/ Secretary Timberlake approved DPH/DMHSAS to publicly launch the Integration Joint Statement. The Joint Statement, Endorsement Form, and Action Step Objectives are at: http://dhs.wisconsin.gov/mentalhealth/jointstatement/index.htm. The Children's Mental Heath Committee focuses attention on Primary Care Mental Health Screening and EPSDT. //2010//

Relationship with Social Services and Child Welfare

There are 72 public child welfare programs with services provided by county human or social service departments and the Bureau of Milwaukee Child Welfare in Milwaukee County. Eleven Indian tribes each provide child welfare services. The Division of Children and Family Services (DCFS) is the state child welfare agency that supervises the delivery of child welfare services of counties. WI provides approximately half of the funds for child welfare services and the counties provide the remaining.

WI's Child Welfare Program Enhancement Plan (PEP) is a two-year plan to implement system-level change designed to achieve the newly established federal standards for child protection. It promotes collaboration to establish and implement best practices.

The MCH program maintains working relationships with DCFS and county social services to prevent child maltreatment and promote the health and well being of children in out-of-home placement. MCH works to promote evidence-based, home visiting programs in 10 sites across the state and in Milwaukee County and collaborates with the University of WI-Extension to provide quality training for staff providing home visiting.

/2007/ WI's Children's Trust Fund, with Prevent Child Abuse WI and Child Abuse Prevention Fund of Children's Hospital and Health Systems presented the State Call to Action to End Child Abuse and Neglect: WI's State Plan to Prevent Child Maltreatment to DHFS Secretary on 2/6/06. Recommendations in the State Plan will be used to advise MCH programs including home visiting and efforts to reduce infant mortality. //2007//

/2008/ The Governor proposes a Department of Children and Families (DCF) to strengthen the system of services for children and families. DCF will unify programs from DHFS and DWD that serve the social and financial needs of children and families. This assures WI children have opportunities to grow up safe, healthy, and successful in strong families by consolidating programs to strengthen access to and coordination of services. The Governor proposes to implement universal home visiting to all new first-time parents and expand targeted home visiting to parents at-risk of child maltreatment. Improvements to child welfare are: increase the foster care rate, fully fund projected caseloads in Milwaukee County programs, and welfare program staff recruitment and retention. //2008//

/2009/ DCF was created with the passage of the budget combining the TANF program, W-2, and the state child welfare systems. On 7/1/08, the DPH home visiting programs, Family Foundations and Empowering Families of Milwaukee, will be administered by DCF. During transition MCH will continue connections with the DCF and focus on sustaining program integrity and quality to avoid disruption of services. //2009//

/2010/ Continued support of DCF occurs during transition per MOU until 12/31/2010. //2010//

Relationship with Education

CYSHCN staff serves on the WI School Parent Educator Initiative advisory board that promotes parent involvement in the education system for students with disabilities.

DPI received a 5-year State Improvement Grant (SIG) and developed the WI State Improvement Plan for Children with Disabilities to improve state systems providing early intervention, education, and transition services to families and children with disabilities. CYSHCN staff serve on the SIG Steering Committee. Parts of this plan enhance the ECCS Grant.

DPH staff was appointed to serve on DPI's Advisory Council for Alcohol and Other Drug Abuse

Programs from 08/01/05 through 08/01/08. Staff serve on DPI's WI Afterschool Network and Oversight Work Group.

/2007/ IPP has been working with DPI in the statewide SPI. DPI participates in monthly SPI meetings. DPI provided support to the EMSC and Injury Prevention Annual Conference, Childhood Emergencies: Prevention and Management. DPI is on the Injury Coordinating Committee, a statewide advisory group that meets quarterly.

DPI and DHFS/DPH implemented a joint plan to promote Comprehensive School Health Programs to increase coordination between LHDs and school districts. DPI-DHFS jointly collaborate on the Governor's School Health Award, reapplication for the 2008 CDC-CSHP 5 year competitive reapplication state grant, the Abstinence Supplemental Grant, support of a WI Sexual Risk Behavior's Data website; the statewide adolescent health Listserv; youth listening sessions; and review of STD data and infrastructure. //2007//

/2008/ DHFS and DPI will establish a new MOA on programs beyond physical activity, nutrition, tobacco, and childhood obesity. DHFS works closely with DPI, WPHA and the WALHDAB to conduct a statewide analysis of school health services. Progress continues to be made on a joint DHFS-DPI asthma management initiative in schools. //2008//

/2009/ DHS and DPI established an MOA highlighting coordination with food safety, childhood lead, diabetes, alcohol and other drug abuse, mental health, unintentional and intentional injury programs with data sharing through 2012. In partnership with DHS, DPI obtained a 5 year, $3.5 million grant from CDC, to promote physical activity, nutrition, and coordinated school health programs, to prevent HIV and tobacco use and to conduct the Youth Risk Behavior Survey. DHS will convene an Expert Policy Panel for DPI to meet requirements from the Center for Best Practices Healthy Kids, Healthy America Grant.

DPI receives ECCS grant funds for Regional coach activities. CYSHCN staff provide consultation to 2 new DPI initiatives: a 5 year State Improvement Grant for a teacher/personnel development plan and other DPI special education goals, and response to Intervention initiative to enhance math, reading and social-emotional development for students in special education to change school culture for all students. //2009//

/2010/ DHS Expert Policy Panel of nutritionists and physical activity practitioners convened for DPI completed work in fall 2008 and submitted recommendations to Legislative Study Council focusing on Childhood Obesity. Regional Coaches contracts continue for ECCS. //2010//

Relationship with Early Childhood Comprehensive Systems (ECCS)

The ECCS grant increased MCH state-level capacity and focuses on the early childhood years. The long term objective of WI's ECCS Project focused on systems and infrastructure realignment. Under MCH leadership a shift toward greater communication has evolved among stakeholders from the 5 ECCS component areas, with a growing interest in systems integration for young children and their families.

/2007/ Four goals have been embraced by stakeholders in early childhood with strategies under development promoting cross systems integration of the ECCS Implementation Plan to support stronger collaboration with many partners interested in positive outcomes for young children and their families. //2007//

/2008/ No significant change. //2008//

/2009/ In June 2007 the MCH program contracted with WI Alliance for Infant Mental Health to lead state efforts to increase systems coordination and advance the ECCS implementation plan.

The MCH Infant/Child Health Consultant monitors this contract and joined the State ECCS Action Team. //2009//

/2010/ ECCS grant extended to 5/31/09. Application for continuing ECCS funds through 2012 was submitted. Wisconsin Early Childhood Collaborating Partners System Plan was revised to support and link with work of the Governor's Advisory Council on Early Learning and Care, appointed in January 2009. //2010//

Relationship with Department of Justice (DOJ)

DOJ is a member of the IPP's CDC grant, WI Violent Death Reporting System Technical Advisory Board (TAB). DOJ manages the state's Child Death Review Team. Membership includes the MCH Chief Medical Officer and DPH staff.

/2007/ The IPP began work with DOJ in their development of CASEPOINT, a real time web based reporting system for Coroners and Medical Examiners that includes data elements needed by DOJ. //2007//

/2008/ No significant change. //2008//

/2009/ A CDR manual was developed by CHAW with Title V support and held 2 trainings for local teams. A DUA was signed between DHS-Injury Prevention Program and MI Institute of Public Health for the State's CDRT to promote a standardized data collection and a state and national data system. Trainings for local teams began. The State team is exploring alternatives for location of this team, legislation and models of other states, and sustainability of CDRTs at a local level. DOJ participates on the WVDRS TAB. The Sexual Assault Prevention Program and WI Coalition Against Sexual Assault partner with DOJ's Office of Crime Victim Services and OJA on service provision and primary prevention of sexual violence. //2009//

/2010/ WI will receive $234,682 as one of 38 states involved in Mattel, Inc. and Fisher-Price settlement. Monitored by DOJ, MCH and Environmental Health will assist DOJ to utilize the funds to correct home hazards. MCH's home safety assessment is used to identify safety product needs in WI homes. //2010//

Relationship with SSA, Voc Rehab, Disability Determination, and Transitions

The Disability Determination Bureau (DDB) within DHFS has the SSA contract to determine eligibility of all SSI applicants including those under age 16. Monthly the DDB sends names of new child applicants to the CYSHCN Program. CYSHCN sends information to families about the state's Regional CYSHCN Centers and other resources. Outreach by the Regional CYSHCN Centers includes contact with local SSA and Division of Vocational Rehabilitation (DVR) offices. DVR, SSA, and the Regional CYSHCN Centers are youth-to-adult transition stakeholders participating with the State CYSHCN Program in the Statewide Healthy and Ready to Work Transition Consortium.

/2007/ In 2006 the WI Trauma Brain Injury Advisory Board was upgraded to the WI Brain Injury Advisory Council. Two MCH CYSHCN and IPP staff were appointed to the Council. //2007//

/2008/ The Brain Injury Advisory Board reports/advises the DHFS Secretary on statewide brain injury issues. //2008//

/2009/ No significant change. //2009//

/2010/ WI continues a Community of Practice on Transition in collaboration with many partners. A Practice Group on Health was established which recently published "Transition Health Care Checklist: Preparing for Life as an Adult" and "My Health Pocket

Guide." See http://www.waisman.wisc.edu/wrc/pub.html. //2010//

Relationship with AODA

See discussion under "Relationship with Mental Health".

DPH's Youth Policy Director serves on the AODA State Incentive Grant Advisory Committee staffed by the DDES's BMHSAS. The goal is to create a state plan addressing substance abuse prevention for youth 12 to17. The committee embraced the AODA objectives within the Healthiest WI 2010 State Health Plan.

/2007/ DDES/BMHSAS in consultation with DPH will work to re-establish the AODA Prevention Committee under the auspices of the State Council on Alcohol and Other Drug Abuse focusing on underage drinking. Additional work is occurring on a statewide AODA needs assessment on conditions, magnitude and severity of the substance abuse problems to prioritize the Substance Abuse Block Grant funds.

In 2006 DPH participated in a joint divisional discussion on the National Underage Drinking Initiative Town Hall meeting on evidenced-based strategies to reduce underage drinking. With support from the SAMHSA funded Epidemiologic Workgroup, an analysis and surveillance of the alcohol data will be conducted creating an underage drinking compliance checks program if a federal grant is awarded. //2007//

/2008/ DMHSAS received a SAMHSA grant - Project Fresh Light, to assess AODA services provided to youth. The Youth Policy Director, CYSHCN staff, and IPP staff collaborate with this program. Project Fresh Light is to identify fiscal, regulatory, and policy barriers that impede the provision of accessible evidence-based treatment across a continuum of care; devise and implement strategies with other State agencies that fund and/or regulate these services; and improve access to treatment capacity available in communities. The Youth Policy Director was appointed to the DMHSAS State Prevention/Substance-Abuse Prevention Framework-State Incentive Grant Advisory Committee. //2008//

/2009/ The Bureau of Substance Abuse Services has joined the initiative for the "The Integration of Physical Health, Mental Health, Substance Use and Addiction". (See IIIB MCH Advisory Committee) DMHSAS implements the second year of a $2.1 million State Prevention Framework-State Incentive Grant. DPH received $65,000 for an epidemiological alcohol and drug abuse impact study to augment the grant. The focus includes risky drinking behavior (binge or underage) among 12-25 year olds and alcohol related motor vehicle fatalities, injuries, and crashes for individuals ages 16 to 34. //2009//

/2010/ Issued 5 subcontracts to 5 regional coalitions for delivery of SPF-SIG Grant. DHS Youth Policy Director continues on DMHSAS' State Governor's State Council on Alcohol and Other Drug Abuse, Prevention/SPF SIG Advisory Committee. //2010//

Relationship with Federally Qualified Health Centers

Implementation of the Medicaid Family Planning Waiver has been an opportunity for the Title V to work in collaboration with FQHCs to promote access to contraceptive and primary care services.

/2007/ No significant change. //2007//

/2008/ Renewal application expands collaboration. //2008//

/2009/ Representatives from 2 Milwaukee FQHCs, Milwaukee Health Services, Inc. and 16th St. CHC participated in the HRSA-organized Healthy Birth Outcomes review. //2009//

/2010/ MCH program works with Milwaukee Health Services to pilot Centering Pregnancy group prenatal care model with teens. //2010//

Relationship with Primary Care Associations

There is little involvement with primary care associations as Title V focus is infrastructure development and system building. The CYSHCN Program's medical home initiative and the Reproductive Health Program works closely with select primary care providers.

/2007/ The WI Primary Health Care Association (WPHCA) assists community health centers (CHCs) to expand oral health service capacity, and works with the Title V-funded Dental Hygienist, Chief Medical, and Chief Dental Officers; all 3 were speakers at their annual oral health conference. The CYSHCN Program, in collaboration with its Regional Centers, established Medical Home activities at 2 CHCs (Marshfield Clinic - Chippewa Falls and 16th Street CHC). The administrator of the CHC for Marshfield Clinics presented a model of Medical and Dental Home at the 2006 Medical Home Summit. //2007//

/2008/ Oral Health Program staff provide technical support to the WPHCA for grant applications to increase capacity for oral health at community health centers. Regular bi-monthly meetings occur between staff of the Oral Health Program, the WPHCA, and the WI Office of Rural Health. The purpose is to promote activities that improve access to oral health care for the underserved. //2008//

/2009/ WPHCA is connected to an oral health efficiency program in Milwaukee. Medical Home implementation strategies used by CHCs were highlighted at a 2007 Summit. //2009//

/2010/ CYSHCN Program partners with CHCs, WPHCA and others in Healthcare Partnerships Initiative in Milwaukee to promote Medical Home. One time dental access grants were awarded to 4 CHCs in an effort to build capacity. //2010//

Relationship with Tertiary Care Facilities

The Congenital Disorders Program (newborn screening) has contracted to provide diagnostic and treatment services for identified infants at pediatric centers: Children's Hospital of WI (CHW), UW Hospital and Clinics including Waisman Center, La Crosse Gundersen, and Marshfield Clinic. Providers at tertiary facilities provide genetics services, outreach and implement birth defects reporting to the new WI Birth Defects Registry (WBDR) under contract. The CYSHCN Program, as part of the funded WI Integrated System for Communities Initiative (WISC-I), work with the UW-Pediatric Pulmonary Center and CHW to establish processes to transition youth with special health care needs to adult tertiary care.

The number of neonatal intensive care units in WI has increased from 6 in the 1970s to 19 in 2004.

/2007/ Both the UW-PPC and CHW identified quality improvement teams from their specialty clinics as part of the WISCI learning collaborative. Marshfield Clinic now receives MCH funding to support genetic services in northern and western WI.

The number of NICUs has increased to 21. In October 2005, WAPC held an invitational meeting on regionalized perinatal care to determine how WI could transition from 2 levels of perinatal care (community hospital and perinatal center) to the 6 levels of care supported by the AAP. //2007//

/2008/ WAPC leads efforts to transition levels of perinatal care. Criteria sets for the 6 levels of care will be finalized and sent to birth hospitals to conduct self assessments and determine their care level. A process and external review group will be established to use criteria and deal with discrepancies in levels of care results. A WAPC program committee deals with tertiary care

issues. //2008//

/2009/ WAPC has established criteria for 6 levels of perinatal care associated with the AAP levels of neonatal care. Criteria worksheets and self assessment materials are found at www.perinatalweb.org. WAPC offered distance-based education on the self-assessment initiative. The WAPC Tertiary Care Committee reviews completed self-assessments. //2009//

/2010/ 25 WI hospitals providing perinatal care completed the WAPC self assessment tool on levels of perinatal care. //2010//

Relationship with Public Health, Health Professional Educational Programs, and Universities

Title V coordinates with the UW Schools of Medicine and Nursing, Population Health, and Waisman Center and has worked together on activities: Needs Assessment, Pediatric Pulmonary Center, WI Sound Beginnings, and Medical Home Learning Collaborative. Student internships are available in the Title V Program. UW DoIT partners in the development of PHIN. The UW Extension system is a partner in training and education. Relationships exist with the State Laboratory of Hygiene, Medical College of WI, Marquette School of Dentistry, the Schools of Nursing at the UW-Milwaukee and Marquette, and the UWM School of Communication, on Medical Home, oral health, perinatal care, birth defects surveillance and prevention, and early hearing detection and intervention.

/2007/ Title V staff are involved with the new UW School of Medicine and Public Health as mentors and students. //2007//

/2008/ No significant change. //2008//

/2009/ The oral health program partners with the Marquette Dental School and 2 technical colleges to improve dental access and provide provider training. The MCHB-funded CSHCN Oral Health grant provides training specific to meet the needs of children with special needs. A strong working relationship with our new school of public health was established. A fellow, several MPH students, pediatric residents and undergrad students have worked with DPH. //2009//

/2010/ MCH program has a 2 year CSTE MCH advanced epidemiology fellow. Six pediatric residents, 3 MPH students, and 10 medical or nutrition students have spent at least 1 month with MCH. CYSHCN Program collaborates with Waisman Center UCEDD/LEND on early identification and ASD initiatives. Oral Health Program provides funding and partnership support to Marquette University and Chippewa Valley Technical College to enhance capacity. //2010//

F. Health Systems Capacity Indicators

Introduction

2006 data are required by the TVIS for the Health System Capacity Indicators (HSCIs), forms 17, 18, and 19, for the 2008 Title V MCH Block Grant Application; however, 2006 data are only available for #08. Therefore, from administrative data bases, we used the most recent available data (2005) for #01, 04, and 05A-D; SFY 2006 data are used for #02, 03, 06A-B, 07A-B.

#05A-D are of particular significance since the WI DHFS Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, is one of the department's priorities.

#09A-B reflect our program capacity to analyze and access state databases relevant to MCH program issues. We use the HSCIs to supplement our program needs and assess our data capacity in relationship to our MCH issues. The HSCIs complement the data indicators in WI's State Health Plan, Healthiest WI 2010: A Partnership Plan to Improve the Health of the Public, and KidsFirst: The Governor's Plan to Invest in Wisconsin's Future, 2004.

Indicator #09A-B indicates that WI's Title V Program has excellent data from several sources. The SSDI grant is addressing the coordination of data linkages across registries and surveys. WI was awarded PRAMS in 2006.

/2009/ 2007 data are required by the TVIS for the HSCI forms 17, 18, and 19, for the 2009 Title V MCH Block Grant Application; however, 2007 data are only available for #08. Therefore, from administrative data bases, we used the most recent available data (2006) for #01, 04, and 05A-D; SFY 2007 data are used for #02, 03, 06A-B, 07A-B. //2009//

/2010/ 2008 data are required for HSCI forms 17, 18, and 19; however 2008 data are only available for #08. Therefore, from administrative data bases, we used most recent available data (2007) for #01, 04, and 05A-D, SFY 2008 data are used for #02, 03, 06A-B, 07 A-B. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	26.9	27.0	27.0	20.9	20.9
Numerator	914	926	926	751	751
Denominator	339661	342755	342755	358829	358829
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Numerator: Wisconsin Department of Health and Family Services, Wisconsin Hospital Discharge Data, Bureau of Health Information and Policy, 2008. Multiple hospitalizations of the same child are de-duplicated.
Denominator: Wisconsin Dept. of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http:// dhfs.wisconsin.gov/wish/,Population Module, accessed 4/21/09.

Notes - 2006
Source: Numerator: Wisconsin Department of Health and Family Services, Wisconsin Hospital Discharge Data, Bureau of Health Information and Policy, 2007.
Denominator: Wisconsin Dept. of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http:// dhfs.wisconsin.gov/wish/,Population Module, accessed 5/17/07.

Narrative:
Wisconsin's Health Systems Capacity Indicators (Forms 17, 18, 19) present data demonstrating Wisconsin's ability to understand women's and children's health issues in the context of the Title V MCH/CSHCN Program Block Grant. The population served by Title V MCH/CSHCN Program in Wisconsin is small. Nonetheless, we use these data to strengthen existing programs, examine

policy issues, encourage policy development, and program implementation to help women, children, and families. These data also bridge Title V MCH/CSHCN Program services to other public health programs in the DPH and agencies that work with families. Below is a brief summary of each indicator.

Our methodology for this indicator changed in 2000; the rate (per 10,000 less than 5 years of age) of children hospitalized for asthma was 25.7 per 10,000 for 2002-2004, using the most recent data available. 2005 data are provisional.

/2008/ In 2001, Children's Health Alliance of Wisconsin (CHAW), with funds from the MCH Program established the Wisconsin Asthma Coalition (WAC). The WAC mission is to develop and implement a sustainable statewide action plan that expands and improves the quality of asthma education, prevention, management, and services and eliminates the disproportionate burden of asthma in racial/ethnic and low-income populations. Since its inception, the coalition has grown to over 200 members and in 2004, the Wisconsin Asthma Plan was created and implemented. The WAC supports local asthma coalitions throughout Wisconsin. These local coalitions endorse WAC's vision and mission and have adopted the Wisconsin Asthma Plan. Currently there are 9 local asthma coalitions across the state. The Wisconsin Academy of Pediatrics Foundation partners with the CHAW and the Medical College of Wisconsin to coordinate and manage the Allergist Outreach Asthma Education Program for Primary Care Practices. This program promotes early and accurate diagnosis of asthma, and use of evidence-based strategies and guidelines within the practice of clinicians and nurses. In Wisconsin, 8% of children have been diagnosed with asthma. Children age 11-17 years have the highest prevalence of asthma, while children age 0-4 years have the highest emergency department visit and in-patient hospitalization rates. Children age 0-4 years have the lowest prevalence of asthma (5-6%) which may be due to the difficulty in establishing an asthma diagnosis in very young children. //2008//

/2009/ Revision of the Wisconsin Asthma Plan was initiated at a statewide meeting of the Wisconsin Asthma Coalition in March 2008 based upon the Burden of Asthma in Wisconsin-2007 report. The revised plan is expected to be completed by spring 2009 and will address, among other things unique to the state, services needed for persons of racial and ethnic minority groups. Biannual Wisconsin Asthma Coalition meetings continue to provide opportunities to hear from local, state, and national experts and to network. The rate of asthma hospitalizations for children declined in 2007. //2009//

/2010/ State asthma plan for 2009-2014 was released at spring coalition meeting May 14-15, 2009. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	97.1	97.5	97.7	96.4	97.5
Numerator	29661	30357	31833	32934	34297
Denominator	30539	31149	32585	34154	35180
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2008.

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Narrative:
Overall, a large proportion of Wisconsin's Medicaid and SCHIP (BadgerCare) enrollees received services; 97.5% and 95.2% respectively during SFY05. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185% of the federal poverty level (FPL). Families remain eligible for BadgerCare until their income exceeds 200% FPL. BadgerCare has increased enrollment of children in Medicaid. Many BadgerCare families are mixed with younger children in Medicaid, who are eligible for Healthy Start with incomes up to 185% of the FPL, and older siblings and parents in BadgerCare. An increase in the percentage of infants to age one receiving at least one EPSDT service from BadgerCare is due to continued program expansion.

/2008/ A large proportion of Wisconsin's Medicaid enrollees under age one year continue to receive services; 97.7% during SFY06. BadgerCare continues to increase enrollment of children in Medicaid. BadgerCare Plus, as proposed in Governor Doyle's 07-09 budget, will assure insurance coverage for all children in Wisconsin. //2008//

/2009/ Although declining slightly to 96.4% in 2007, overall a great percentage of Medicaid enrollees under the age of one year are reported as receiving at least one initial periodic health screen. This number should continue to increase as families' access coverage under the expanded Medicaid program, BadgerCare Plus. BadgerCare Plus was passed as a part of Governor Doyle's 07-09 biennial budget and is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. The program began enrolling participants in February 2008. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. It is not designed to replace private insurances so specific rules are in place that do not allow most people to drop their private insurance to participate. Families with kids at higher income levels will pay premiums and co-payments for certain services. The plan has two benefit plans--the Standard Plan which covers usual Medicaid services, and the Benchmark Plan which covers usual health care services but fewer optional Medicaid services. The plan received depends on a participant's income. BadgerCare Plus also covers the following groups of persons:
• Pregnant women (up to 300% of the Federal Poverty Level (FPL), which is $51,510 for a family of three);
• Parents and caretakers at higher income levels (up to 200% of the FPL, which is $34,340 for a family of three);
• Young adults who are leaving foster care when they turn 18 (regardless of income);
• Parents with incomes up to 200% FPL who have kids in foster care; and,
• More farm families and self-employed families.
For more information see the following web site:
http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

/2010/ BadgerCare Plus (BC+) continues to expand with an increase in coverage for families. All children under 19 years old -- at all income levels -- can enroll in BC+. Since initiation of program expansion in February 2008, enrollment for children continues to increase, up 26% as of March 2009. As a result, the number of children enrolled in Medicaid during 2008 increased by 69,084, or 22%. This positively impacted results of infants under age one enrolled in Medicaid who received at least one initial periodic screen during the year which increased from 96.5% to 97.5%. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	93.8	95.2	94.5	95.4	92.5
Numerator	1227	1393	1145	1457	1447
Denominator	1308	1464	1212	1528	1564
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2008.

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Narrative:
Overall, a large proportion of Wisconsin's Medicaid and SCHIP (BadgerCare) enrollees received services; 97.5% and 95.2% respectively during SFY05. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185% of the federal poverty level (FPL). Families remain eligible for BadgerCare until their income exceeds 200% FPL. BadgerCare has increased enrollment of children in Medicaid. Many BadgerCare families are mixed with younger children in Medicaid, who are eligible for Healthy Start with incomes up to 185% of the FPL, and older siblings and parents in BadgerCare. An increase in the percentage of infants to age one receiving at least one EPSDT service from BadgerCare is due to continued program expansion.

/2008/ A large proportion of Wisconsin's SCHIP (BadgerCare) enrollees under age one continue to receive services; 94.5% during SFY06. This declined slightly from 95.2% in SFY05 due to unintended consequences of implementing Medicaid program documentation requirements. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. //2008//

/2009/ A large proportion of Wisconsin's SCHIP enrollees under age one continue to receive one periodic screen; 94.5% during SFY07. This remained essentially unchanged from SFY06. The percent of SCHIP enrollees receiving services should increase as families' access coverage under the expanded Medicaid program, BadgerCare Plus. BadgerCare Plus was passed as a part of Governor Doyle's 07-09 biennial budget and is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. The program began enrolling participants in February 2008. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. For more information see the following web site: http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

/2010/ BadgerCare Plus continues to expand with an increase in coverage for families. All children under 19 years old -- at all income levels -- can enroll in BadgerCare Plus. Since initiation of program expansion in February 2008, enrollment for children continues to increase, up 26% in March 2009. Number of children enrolled in Medicaid during 2008 increased by 69,084, or 22%. However most of the increase is for children who are within lower income ranges allowing for usual Medicaid eligibility. Number of children at 250% of FPL eligibility declined slightly over the year and impacted results of infants under age one enrolled per SCHIP requirements who received at least one initial periodic screen during the year decreasing from 95.4% to 92.5%. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	85.2	85.2	84.1	83.9	83.9
Numerator	57732	60407	60831	61067	61067
Denominator	67779	70934	72302	72757	72757
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Wisconsin Divsion of Pulbic Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish, Prenatal Care Module, accessed 04/21/09.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Wisconsin Divsion of Pulbic Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish, Prenatal Care Module, accessed 04/29/08.

Narrative:
2005 data are provisional. In 2004 (final data), 85.2% of Wisconsin women's observed to expected prenatal visits were greater than or equal to 80% on the Kotelchuck index. In 2003, 85% of Wisconsin mothers who gave live birth received first trimester prenatal care. (Note: the methods for calculating the Kotelchuck Index changed in 2003; therefore, we see an increase in the Kotelchuck Index from 2002 to 2003 overall).

/2008/ Programs supporting the maintenance and improvement of quality perinatal services include the Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services. These programs strive to identify women early in their pregnancies and assure they receive early and continuous medical prenatal care. Two statewide projects also help to maintain and improve perinatal services. The Wisconsin Association for Perinatal Care is the statewide project to improve maternal health and maternal care. The Infant Death Center of Wisconsin is funded to improve infant health and reduce disparities in infant mortality.

Although this indicator for Wisconsin's total population (85.2%) and white mothers (88.3%) is quite good, this indicator reflects the disparities in perinatal care and birth outcomes that exist for Wisconsin's racial and ethnic populations at 66.6% for Hmong, 74.5% for Hispanic, 75.1% for African American, and 75.3% for American Indian mothers. The Wisconsin Department of Health and Family Services' Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, described previously, is one of the department's priorities. Obtaining early and continuous quality prenatal care for populations with disparate outcomes will be one of the messages this initiative will emphasize. We will be able to use this measure, along with others, to track the progress we are making. //2008//

/2009/ This indicator for Wisconsin's total population is 84% with white mothers at 87%. The evidence of racial and ethnic disparities is reflected in 74% of Black/African American women with expected prenatal visits greater than or equal to 80% on the Kotelchuck Index; 59% for Hmong/Laotian; 72% for Hispanic/Latino; and 72% for American Indian populations.

The addition of BadgerCare Plus has increased the enrollment options for pregnant women into the Medicaid Prenatal Care Coordination benefit as well as prenatal medical care. Efforts to support adequate prenatal care continue through MCH-funded perinatal care coordination services, statewide services provided by the Infant Death Center of Wisconsin and the Wisconsin Association for Perinatal Care (WAPC), and the Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative. //2009//

/2010/ This indicator for Wisconsin's total population is 83% with white mothers at 87%. There is evidence of racial and ethnic disparities reflected in 73% of Black/African American women with expected prenatal care visits greater than or equal to 80% on the Kotelchuck Index, 55% for Hmong/Laotian, 71% for Hispanic/Latino and 70% for American Indian populations.

The expansion of Badger Care Plus has increased enrollment for pregnant women by 20%. Efforts to support adequate prenatal care continue through Medicaid PNCC, MCH-funded perinatal care coordination services, statewide services provided by Infant Death Center and the Wisconsin Association for Perinatal Care. The Healthy Birth Outcomes Project: Evidence Based Practice Workgroup has developed recommendations for practice. Additionally, Medicaid is implementing the Healthy Birth Outcomes Comprehensive Plans to individual health plans statewide. These comprehensive plans will outline the health plan's detailed intent for providing screening, outreach, prenatal and post partum care, health promotion/education, interconception care and infant care to women identified through Healthy Birth Outcomes High Risk Report. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	83.6	93.6	93.9	94.3	93.4
Numerator	346556	416581	430158	435887	439099
Denominator	414652	445102	458207	462296	469934
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2008.

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Narrative:
Generally, a large percentage of Medicaid-eligible children receive services from the Medicaid Program in Wisconsin. 93.6% of Medicaid-eligible children received a service paid by the Medicaid Program in SFY05, an increase from 83.6% in SFY04. We do not know the reason for the decrease in SFY04; it may be from methodological issues or a random fluctuation. We will watch this indicator closely for the next few years.

/2008/ A large percentage of Medicaid-eligible children receive services from the Medicaid Program in Wisconsin. 93.88% of Medicaid-eligible children received a service paid by the Medicaid Program in SFY06, a slight increase from 93.6% in SFY05. An effort to expand the BadgerCare Program in Wisconsin to cover all uninsured children is included in Governor Doyle's 07-09 budget request. //2008//

/2009/ A large percentage of Medicaid-eligible children receive services that are paid for by the Medicaid Program in Wisconsin; the percent increased to 94.3% during SFY 2007. This is a slight increase from 93.9% in SFY 2006 and should continue to increase with the new benefit, the BadgerCare Plus program that was passed in Governor Doyle's 07-09 state budget and began enrolling participants on February 1, 2008. This is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. All children under 19 years old -- at all income levels -- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. For more information see the following web site: http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

/2010/ A large percentage of Medicaid-eligible children receive a service paid by the

Medicaid Program, however, during SFY 2008 the percentage decreased slightly to 93.4%. This occurs at a time when overall number of children covered by Medicaid through BadgerCare Plus during 2008 increased by 69,084, or 22%. All children under 19 years old in Wisconsin -- at all income levels -- can enroll in BadgerCare Plus with premiums levied for families at higher income levels. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	34.0	32.6	32.4	34.5	34.9
Numerator	28647	28599	29611	32228	35248
Denominator	84143	87771	91507	93426	100980
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2008.

Notes - 2007
Data entered for SFY 2007 were wrong for the 2009 Application/ 2007 Report . They are corrected for the 2010 Application/ 2008 Report. Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2008.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Narrative:
32.6% of EPSDT eligible children aged 6 through 9 years received any dental services during SFY05, a slight decrease from 34.9% in SFY05, but a significant decrease from 53.1% in SFY03. We do not know the reason for this decrease, although it may be due to an expansion of the program with a larger number of enrollees but fewer children receiving services. We will watch this closely for the next few years as the program continues to expand.

/2008/ The percentage of EPSDT eligible children aged 6 through 9 years of age has remained stable (2004=34%, 2005=32.6%, & 2006=32.3%) over the last few years. As in other states, it remains a challenge to find dental providers willing to accept new Medicaid patients. Low reimbursement rates are the most commonly mentioned reason. In addition, there is a lack of capacity in the community health center/safety net clinic system. The Wisconsin Medicaid program sent out a Request for Information that will ask for proposals to revise the dental Medicaid component. //2008//

/2009/ The percentage of EPSDT eligible children aged 6 through 9 years of age who had received any dental services during the year had remained relatively stable since 2004. However in 2007 we experienced a rather significant decrease (17.9%). It continues to remain a problem

finding dental providers willing to accept Wisconsin Medicaid. Medicaid reimbursement for dental providers contributes to the problem. Although it varies from state to state, the Medicaid reimbursement rate for dental professionals is typically much lower than private pay patients and doesn't cover office overhead costs associated with treatment. Wisconsin is working aggressively to increase capacity, especially in community health centers and safety net clinics. Currently there is a lack of consistent ongoing dental care in those agencies, which presents another barrier to care. There is a declining dental provider population, with more dentists reaching retirement age and a short supply of new dental graduates. This disparity makes it a challenge for patients to obtain appointments, as well as for communities to retain dental providers. The Wisconsin Office of Rural Health has consistently increased their dental recruitment rates from (5) in 2005 to (15) in 2007, with 14 of the 15 providers placed in community health centers. Wisconsin is unique in that Medicaid reimbursement for dental services is through both fee-for-service and HMO models. The HMO's, who serve the largest portion of Wisconsin Medicaid recipients in and around Milwaukee typically have a lower utilization rate than those in fee-for-service. Wisconsin is examining the usefulness of this relationship and is committed to finding an appropriate solution. //2009//

/2010/ The problem of finding dental providers willing to accept Wisconsin Medicaid continues. Medicaid reimbursement for dental providers additionally presents access problems. The Medicaid reimbursement rate for dental professionals, although varies widely from state to state, is typically much lower than private pay patients and doesn't cover office overhead costs associated with treatment. Wisconsin is working aggressively to increase capacity, especially in community health centers (CHCs) and safety net clinics, recently providing over $1.75 million in one time dental access funds to CHCs. Currently there is a lack of consistent ongoing dental care in those agencies, which presents another barrier to care. There is a declining dental provider population with more dentists reaching retirement and a short supply of new dental graduates. This disparity makes it a challenge for patients to obtain appointments, as well as for communities to retain dental providers. The Wisconsin Office of Rural Health has consistently increased their dental recruitment rates from 10 in 2006 to 16 in 2008, with most placed in CHCs. Wisconsin is unique--dental Medicaid reimbursement is both fee-for-service and HMO. The HMOs who service the largest portion of Wisconsin Medicaid recipients in and around Milwaukee typically have a lower utilization rate than those in fee-for-service. Wisconsin is examining the usefulness of this relationship and is committed to finding an appropriate solution. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	13727	14201	14590	15289	15793
Denominator	13727	14201	14590	15289	15793
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

The denominator, 15,793 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Titles V's role is focused on assuring families are aware of and enrolled in SSI. As such, under an MOU agreement, the Disability Determination Bureau of SSA electronically provides the CYSHCN program names and addresses of children under age 16 who have applied for SSI benefits.
The CYSHCN program provided information and resource materials to 2,040 families who made application to SSI. Direct services were provided to 248 clients less than 16 years of age on SSI through agencies reporting in SPHERE.

Notes - 2007
The denominator, 15,289 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Titles V's role is focused on assuring families are aware of and enrolled in SSI. As such, under an MOU agreement, the Disability Determination Bureau of SSA electronically provides the CYSHCN program names and addresses of children under age 16 who have applied for SSI benefits. In 2007, 2,416 families were sent information from the CYSHCN program about the regional CYSHCN Centers, Family Voices, Birth to 3 and other disability resources, whether or not they were found eligible for SSI.

Notes - 2006
The denominator, 14,590 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Titles V's role is focused on assuring families are aware of and enrolled in SSI. As such, under an MOU agreement, the Disability Determination Bureau of SSA electronically provides the CYSHCN program names and addresses of children under age 16 who have applied for SSI benefits. In 2006, 2,685 families were sent information from the CYSHCN program about the regional CYSHCN Centers, Family Voices, Birth to 3 and other disability resources, whether or not they were found eligible for SSI.

Narrative:
All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid program which provides comprehensive rehabilitative services. The CSHCN Program, through an MOU with SSA, receives the names and addresses of all children less than 16 years old making application to SSI, and on a monthly basis, sends information about the Regional CSHCN Centers and other resources to these families.

/2008/ No significant change. //2008//

/2009/ As of December 2007, 15,289 children under the age of 16 received SSI payments, and as mentioned above are automatically eligible for Wisconsin Medicaid program. The CYSHN program provided information and resource information to 2,416 families who have made application to SSI. Direct services were provided through the CYSHCN Regional Centers to 247 clients less than 16 years of age on SSI. //2009//

/2010/ As of December 2008, 15,793 children under age 16 received SSI benefits and are automatically eligible for the Wisconsin Medicaid Program. The CYSHCN Program provided information and resource materials to 2,040 families who made application to

SSI. Direct services were provided to 248 clients less than 16 years of age on SSI through agencies reporting in SPHERE. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	8.8	5.8	6.9

An attachment is included in this section.

Narrative:
Women who did not have Medicaid as a source of payment for the birth had better perinatal outcomes than women who were on Medicaid (05A-05D). In 2004, the percentage of low birth weight (LBW) babies was almost twice for women who were on Medicaid compared to non-Medicaid women (8.0% to 4.1%).

/2008/ The attached table presents data for Indicator #05A by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - HSCI (Table 5A)

On average, Wisconsin's perinatal data are driven by the good outcomes of the white, majority population. This table shows that among mothers who are Medicaid-eligible, some racial and ethnic groups compare favorably to the majority white population. However, it holds true for LBW, that the greatest disparities exist for African American mothers, both Medicaid-eligible and non-Medicaid. (For all the Health System Capacity tables showing race and ethnicity, numbers for Hawaiian and Pacific Islander and Unknown are very small, with extreme percents, and therefore should be ignored.)

Programs supporting the maintenance and improvement of perinatal outcomes include the Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services. These programs provide psychosocial support to enhance the medical prenatal and postpartum care. Services include outreach, assessment of strengths and needs, care coordination, health education and nutrition counseling. Two statewide projects also help to maintain and improve birth outcomes. The Wisconsin Association for Perinatal Care is the statewide project to improve maternal health and maternal care. The Infant Death Center of Wisconsin is funded to improve infant health and reduce disparities in infant mortality. These projects are providing education to health care providers and consumers, promoting preconception care as a key strategy to improve birth outcomes, supporting pilot projects in communities with high rates of disparities in birth outcomes, and supporting coalition-building activities.

As mentioned in HSCI #4, the Wisconsin Dept of Health and Family Services' Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, is one of the department's priorities. LBW rates among all women, both Medicaid and non-Medicaid will be tracked as part of this initiative. //2008//

/2009/ The overall percent of LBW births in 2006 was 6.9%, primarily due to the white majority with (6.2%). The disparities continue with the African American population (13.5%);

Hispanic/Latino (6.2%); American Indian (6.8%); Laotian/Hmong (6.1%). The Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services continue to provide psychosocial support to enhance medical prenatal and postpartum care. A Doctoral research project looking at the birth outcomes of infants born to mothers who received Prenatal Care Coordination services demonstrated PNCC significantly protected against low birth weight, very low birth weight, preterm birth and NICU admission (16-29% less likely to happen). The Infant Death Center of Wisconsin and the Wisconsin Association for Perinatal Care continue to promote preconception health and health care as a key strategy to improve birth outcomes. BadgerCare Plus was implemented in 2008 to increase the number of women who have access to these programs. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

/2010/ The overall percent of LBW births in 2007 was 7.0%, primarily due to the white majority at 6.2%. Disparities continue with the African American population (13.5%); Laotian/Hmong (7.9%); American Indian (7.1%); and Hispanic/Latino (6.4%). The percent of LBW births has become one of the DHS Executive Performance Measures to be monitored and reviewed on an annual basis. Special attention will be paid to tracking LBW of Medicaid births. Because African American LBW rate is the highest among all racial and ethnic populations in Wisconsin, our efforts are primarily focused on that population. Action steps for this indicator include the following: 1) continue efforts to target First Breath (smoking cessation for pregnant women) and other MCH initiatives to African American women; 2) implement the social marketing campaign to address the underlying social determinants of health, including the importance of not smoking during pregnancy and smoke-free environments; 3) continue implementation of recommendations from the Healthy Birth Outcomes Pay-for-Performance workgroup to improve birth outcomes; and 4) implement recommendations from the Evidence-Based Practices sub-committee under the Eliminating Racial and Ethnic Disparities in Birth Outcomes Initiative. Specific topics related to LBW include nutrition and malnutrition and low BMI. Specific recommendations will be made by the workgroup on access to nutritional services. In addition, the WIC Program has funding with a new emphasis in early enrollment and breastfeeding, with special outreach to African American women. LBW by race, ethnicity, and geographic region will be tracked and monitored on an annual basis as part of the DHS Healthy Birth Outcomes Initiative to Eliminate Racial and Ethnic Disparities in Birth Outcomes. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	7.3	4.1	5.2

An attachment is included in this section.

Narrative:
Wisconsin infant birth and death data are maintained by DHFS, DPH, BHIP, Vital Statistics unit and 2003 and 2004 data for infant deaths (matching data files) and the Kotelchuck Index) were not linked as of 7/05/06 by the Bureau of Health Information and Policy. In 2002, the infant mortality rate for births paid for by Medicaid was higher than for births not paid by Medicaid (7.7% to 5.9%); the overall rate was 6.6.

/2008/ The attached table presents data for Indicator #05B by race and ethnicity, using births that

occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5B

Again, according to these data, the greatest disparity is between the white rate and African American rate. For this reason, we are focusing our initial efforts to eliminate racial and ethnic disparities in birth outcomes, with the African American communities in our state. The Hispanic infant mortality rate, 9.5, for "Other" (insured, self-payer, or unknown) was calculated from 12 deaths/1,262 births; for Medicaid, there were 28 deaths and 4,925 births or 5.7 deaths/1,000. See also, HSCI 05A. //2008//

/2009/ The total outcomes in Wisconsin reflect a low mortality due to the white population data with 4.9 infant deaths per 1,000 live births. The disparities are reflected in the outcomes by race and ethnicity with 17.2 Black infant deaths per 1,000 live births and 6.3 Hispanic infant deaths per 1,000 live births. As stated earlier, the Medicaid Prenatal Care Coordination program along with the MCH-funded perinatal care coordination program are providing direct, strength based services to pregnant women to help to reduce these disparities. The regional Healthy Babies Action teams are focused on identifying population based strategies to reduce disparities in outcomes. In addition, Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

/2010/ In addition to programs mentioned last year, and as described elsewhere in this document, Wisconsin is implementing a mulit-year, multi-faceted effort to eliminate racial and ethnic disparities presented in the table above. The MCH Program and the Healthy Birth Outcomes Initiative are making concerted efforts to collaborate with the Medicaid Program because many of the premature and LBW births and infant deaths occur to Medicaid-eligible women. The attention to healthy birth outcomes by the Medicaid Pay-for-Performance program has been mentioned elsewhere. One important step will be the creation of a high risk registry, documenting those women in Medicaid who have had a previous poor birth outcome, so that information will be available to managed health care plans for active management of high risk pregnancies. In addition, managed health care plans are required to submit a comprehensive plan, detailing how they will provide care and manage care of high risk pregnant women. The MCH Program has been an active participant in these efforts. Close and active monitoring of use of the registry and high risk pregnancy plans, and attention to the recommendations from the Fetal and Infant Mortality Review teams, are crucial, along with provider and consumer education and behavioral change, to close the gap in infant deaths between the Medicaid and Non-Medicaid population. There is currently a collaborative effort between LHDs, CDR, and FIMR to expand the Milwaukee FIMR with a regional approach including 4 high risk communities for disparities in birth outcomes. The effort will create a uniform approach to data abstraction and maintenance of data, with each community organizing a review team locally. The previous funding source for Milwaukee FIMR, the Black Health Coalition's Milwaukee Healthy Beginnings Project (a Federal Healthy Start Project) has chosen to no longer fund FIMR. Collaborative efforts are in place to explore and secure funding for a regional FIMR. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	73.4	89.4	83.6

Notes - 2010
In 2007, there were 72,757 resident live births in Wisconsin. Of these, 68,712 (94.4%) resident births were matched with a birth-to-hospital-record match; The hospital record is the only available sources for payer information. 4,045 of 72,757 resident births could not be matched to a hospital discharge record.

An attachment is included in this section.

Narrative:
2004 data for prenatal care utilization also show that women on Medicaid had lower percentages compared to women not on Medicaid (74.6% to 92.9% respectively) first trimester prenatal care and 85% overall.

/2008/ The attached table presents data for Indicator #05C by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5C

For this indicator, the differences between Medicaid-eligible and non-Medicaid for all racial and ethnic groups is striking (showing much better rates for women not on Medicaid). These data also show that for entry into first trimester care for women on Medicaid, efforts are especially needed to reach Hispanic and Asian women. The new BadgerCare prenatal benefit provides Medicaid coverage to undocumented and incarcerated women and should make a change in this indicator. See also HSCI 04. //2008//

/2009/ While the percentage of women receiving first trimester prenatal care is good for the state overall (84%) and white women (87%), disparities exist for Black (74%), Hmong (59%), American Indian (72%) and Hispanic (72%) women.

The addition of BadgerCare Plus has increased the enrollment options for pregnant women into prenatal medical care as well as the Medicaid Prenatal Care Coordination benefit. PNCC and MCH-funded perinatal care coordination services strive to identify women as early as possible in their pregnancies and support early and continuous prenatal care. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. The Medicaid Program is developing on-line express enrollment for pregnant women and newborns. //2009//

/2010/ While the percentage of women receiving first trimester prenatal care is good for the state overall (83%) and white women (87%), disparities continue for Black (73%), Hmong (55%), American Indian (70%), and Hispanic (71%) women. The expansion of BadgerCare Plus showed a 20% increase in enrollment of pregnant women in 2008. DHS has identified access to first trimester prenatal care as an executive performance measure. The action steps to achieve the goal of 88% statewide include: 1) improve outreach of the Medicaid PNCC program; 2) improve communication amongst PNCC providers, medical providers and health plans; 3) support Centering Pregnancy pilot project at Milwaukee Health Services; and 4) continue to explore feasibility of a regional FIMR. Additionally, Centering Pregnancy is being piloted as a model of prenatal care with increased social and emotional support during pregnancy. This pilot will target primarily African American teen mothers. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	76.1	89.8	84.9

Notes - 2010
In 2007, there were 72,757 resident live births in Wisconsin. Of these, 68,712 (94.4%) resident births were matched with a birth-to-hospital-record match; The hospital record is the only available sources for payer information. 4,045 of 72,757 resident births could not be matched to a hospital discharge record.

An attachment is included in this section.

Narrative:
Wisconsin infant birth and death data are maintained by DHFS, DPH, BHIP, Vital Statistics unit and 2003 and 2004 data for infant deaths (matching data files) and the Kotelchuck Index) were not linked as of 7/05/06 by the Bureau of Health Information and Policy. In 2002, 69.5% of women on Medicaid received adequate prenatal care compared to 84.4% of women were not on Medicaid and 78.4% overall. (Note: the methods for calculating the Kotelchuck Index changed in 2003 [although data for the Medicaid and non-Medicaid populations were not linked as of 7/05]. Therefore, we see an increase in the Kotelchuck Index from 2002 to 2003 overall).

/2008/ The attached table presents data for Indicator #05D by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5D

These data present a consistent pattern in Wisconsin, that for all racial and ethnic groups, Medicaid women do not fair as well as their non-Medicaid counterparts regarding adequacy of care. Similarly, disparities exist between whites and all other racial and ethnic groups, for both Medicaid and non-Medicaid women. The Medicaid Program has joined in partnership with DPH in the efforts we are pursuing for the disparities in birth outcomes initiative. See the 2006 Progress Report on the Framework for Action at www.dhfs.wisconsin.gov/healthybirths/. It will be helpful to review these data with Medicaid staff and to track these as we continue to work together. See also, HSCI 04. //2008//

/2009/ BadgerCare Plus was implemented in 2008 to increase the number of pregnant women receiving early access to healthcare. The program provides for the uninsured as well as the underinsured populations in the State of Wisconsin. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

/2010/ Wisconsin's Division of Health Care Access and Accountability (DHCAA) is

implementing Healthy Birth Outcomes Comprehensive Plans. This includes a high risk birth report to all health plans and required written plan addressing strategies for meeting the medical needs of women on BC+ who are at high risk for a poor birth outcome from each health plan. The identified population includes women up to age 45 who meet one or more of the following criteria: prior poor birth outcome; chronic health condition; reside in high risk zip code of Milwaukee; smokes; African American. Each plan will outline details for screening, outreach, engagement, prenatal and postpartum care, education, interconception care and infant care. Submitted plans will be reviewed collaboratively by DHCAA and DPH with suggestions for improvement based on findings of the Evidence-Based Practice Workgroup being shared with individual health plans. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ Governor Jim Doyle has proposed BadgerCare Plus, which would combine the current Family Medicaid, BadgerCare (SCHIP), and Healthy Start eligible populations and programs. The following new populations are proposed, with implementation beginning no sooner than January 2008.

1. All children (birth to age 19) with incomes above 185% of the federal poverty level (FPL)
2. Pregnant women with incomes between 185 and 300% of the FPL
3. Parents and caretaker relatives with incomes between 185 and 200% of the FPL
4. Caretaker relatives with incomes between 44 and 200% of the FPL
5. Parents with children in foster care with incomes up to 200% of the FPL
6. Youth (ages 18 through 20) aging out of foster care
7. Farmers and other self-employed parents with incomes up to 200% of the FPL, contingent on depreciation calculations

In addition, Wisconsin will streamline eligibility; assist employees in purchasing quality, employer-sponsored coverage; and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967. The state is also seeking federal approval for the changes. BadgerCare Plus is targeted for implementation January 1, 2008. //2008//

/2009/ BadgerCare Plus is implemented, February 2008, with the new categories outlined above. Federal approval is being sought to cover childless adults. The Medicaid Program is developing on-line express enrollment for pregnant women and newborns. //2009//

/2010/ On-line express enrollment services are available for pregnant women, newborns, and children through access.wisconsin.gov.

Milwaukee County adult residents eligible for the GAMP program have been enrolled into the new BadgerCare Plus Core Plan for adults with no dependent children. However, start-up planned for June for all others may be delayed in the Governor's budget. Medicaid/BadgerCare Plus women who have experienced a pregnancy loss and have no other children are eligible for BadgerCare Plus Core services, and therefore could receive interconception care. Family Planning Waiver services will also be available to BadgerCare Plus Core eligible women. Wisconsin is currently considering including males in the family planning waiver services.

BadgerCare Plus also has a plan for pregnant women who have been denied BadgerCare Plus because of their immigration or citizenship status or who are in prison or jail. For more information, see the BadgerCare Plus Prenatal Services fact sheet at badgercareplus.org/pubs/p-10026.pdf. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ See narrative for 06A. //2008//

/2009/ See narrative for 06A. //2009//

/2010/ See narrative for 06A. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Pregnant Women	2008	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ See narrative for 06A. //2008//

/2009/ See narrative for 06A. //2009//

/2010/ See narrative for 06A. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
The Title V MCH/CSHCN Program has timely data from several other sources, including: linked infant birth and death files, linked birth certificates and Medicaid eligibility files, and linked birth

records and WIC eligibility files. Birth records and NBS files are not linked; however, the SSDI grant is addressing that issue. SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy and program relevant information. As part of Wisconsin's Birth Defects Prevention and Surveillance System, the WI Birth Defects Registry (WBDR) was developed in 2003 and was rolled out statewide in 2004. The WBDR allows for real-time reporting of birth defects electronically either as individual reports or by uploading from an electronic records system to the secure website. More than 60 reporters are using the WBDR Website to report. One large facility reports by uploading from their electronic patients records system to the WBDR Website. Two additional large facilities are exploring reporting in the same way. A 2005 calendar year report will be finalized in October 2006. The updated version of the WI Early Hearing Detection and Intervention Tracking, Referral and Coordination (WE-TRAC) System was released in late 2005 and a phased roll-out with statewide regional trainings were begun. WE-TRAC is linked to the WI State Lab of Hygiene newborn screening data system and tracks newborns from initial hearing screening through referral. WI was awarded PRAMS in April 2006.

/2008/The Title V MCH/CYSHCN Program has timely data from several other sources, including: linked infant birth and death files, linked birth certificates and Medicaid eligibility files, and linked birth records and WIC eligibility files. WI was awarded PRAMS in April 2006; the first surveys were mailed in May to moms who have had a live birth in early 2007; data for analysis will be available in 2008. Birth records and NBS files are not linked; however, the SSDI grant is addressing that issue. SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy- and program-relevant information. During 2006-2007, WI is working on a data linkage project to link preliminary birth records from the MCH reporting system, SPHERE, to newborn hearing screening records from the Wisconsin Early Hearing Detection and Intervention Tracking, Referral and Coordination (WE-TRAC) System. In the next phase of the project, the linked records will also be linked with birth defects records from the Wisconsin Birth Defects Registry (WBDR). The purpose of the project is to assure that all Wisconsin newborns are accounted for and that appropriate screening and follow-up services are offered to all newborns and their families.//2008//

/2009/SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy- and program-relevant information in a timely manner. In February of 2008, a pilot was completed which found 99% of birth records in SPHERE were able to be matched to a WETRAC record. This pilot demonstrated the ability to successfully link these records. In 2009, Vital Records will implement a new system for receiving and processing birth records which will allow the blood card number to be added to the record and will serve as a unique identifier. This addition will open an opportunity for birth records to be matched to both the Newborn Screening results and Newborn Hearing Screening results.//2009//

/2010/Under leadership of the SSDI Coordinator, the Newborn Health Profile Project began in April 2009 to investigate feasibility of sharing information through linkages of infant birth and death data within Vital Records, Universal Newborn Hearing Screening collected in WE-TRAC, Newborn Metabolic Screening performed by WI State Lab of Hygiene (WSLH), WI Immunization Registry (WIR) and the Lead Program. The Newborn Health Profile will provide information on every infant within the state with access granted (according to HIPAA & FERPA requirements) to public health officials improving quality of population-based data available for surveillance of all newborns in WI. The end result of this project will be a strong and solid proposal clearly defining current data structures, surveillance data needed, plan to extract the data and issues identified that are barriers to full implementation of a Newborn Health Profile.

WI was awarded PRAMS in 2006. 2007 was our first year of data collection; overall response rate was 57%; by stratum, 39% of African American mothers responded compared to almost 80% of White mothers, and 54% for other mothers. For 2008, overall response rate was 54%; by stratum, 35% of African American mothers responded compared to 71% of White mothers, 56% for other mothers. During 2009, we are testing incentives for African American mothers to increase their response rates. We will have PRAMS data from 2007 by mid-2009 for analysis and will present at a conference in October, 2009.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	No
Wisconsin Youth Tobacco Survey	2	Yes

Notes - 2010

Narrative:
The BCHP's Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. The section analyzes the YRBS tobacco questions on a regular basis, and administers the Wisconsin Youth Tobacco Survey every other year. BCHP staff work closely with Wisconsin DPI staff and capacity building for the YRBS; they have regular meetings and are actively involved in the YRBS analysis and dissemination of results.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The following grid depicts the National and State Performance Measures, their objectives and the most recent indicators. We have noted whether or not we have met the objective. The following narrative sections include discussions on Wisconsin's ten state priorities, the national performance activities, state performance measure activities, and other program activities.

See Attachment to Section IV. A. - Background and Overview
(Grids of National and State Performance Measures)
An attachment is included in this section.

B. State Priorities

The Division of Public Health, Bureau of Community Health Promotion, Family Health Section staff identified possible strategies or activities that will help Wisconsin move toward addressing the needs because it is not enough to agree that something is a problem. We must have a reasonable strategy for addressing the problem, in order for it to rise to the level of a priority need or a Wisconsin State Performance Measure. The public health assurance function is carried out in many ways or approaches from: providing services directly, contracting services, developing legislation, educating professionals and consumers, building systems, and/or improving data capacity. During the needs assessment process, staff considered effectiveness, efficiency, and acceptability based on their experience and insight regarding what can work -- within the sphere of control in state government.

1. Effectiveness:
• How effective is this to leading to a solution?
• Is it reachable by known interventions?
• Can it be tracked and measured?
• What are the health consequences of not implementing such a strategy/activity?

2. Efficient:
• How efficient is this to leading to a solution?
• Does the solution produce a result with a minimum of effort, expense, or waste?
• Is this appropriate use of Title V, Block Grant dollars?

3. Acceptable:
• How acceptable is this strategy/activity to clients, providers, and within state government?
• What is the degree of demographic, racial, and ethnic disparity?
• Does this solution help achieve a Healthiest Wisconsin 2010 Health Priority?
• Does this solution help promote the Governor's KidsFirst Initiative?

Wisconsin's 10 Priority Needs

1. Disparities in Birth Outcomes

Disparities in birth outcomes are related to NPM #15, #17, and #18 by addressing very low birthweight and early prenatal care. Wisconsin's continuing SPM #9 addresses the ratio of the Black infant mortality rate to White infant mortality rate.

In 2004, 420 Wisconsin infants died during the first year of life. Of these, 245 were white, and 125 were African American. The white infant mortality rate of 4.5 deaths per 1,000 live births in Wisconsin met the national Healthy People 2010 objective for the first time in 2004. In contrast, infant mortality rates for Wisconsin racial/ethnic minority populations have not met this objective; the African American infant mortality rate was 19.2. The disparity ratio of African American to

white infant mortality rates was 4.3, meaning an infant born to an African American woman was 4.3 times more likely to die before reaching its first birthday than an infant born to a white woman. If African American infant mortality were reduced to the white infant mortality level, 96 of the 125 deaths would have been prevented.

For each racial/ethnic minority group in Wisconsin, the 2002-2004 infant death rate exceeded that of whites. The infant mortality rate of American Indians was 1.8 times greater than the white rate; the rate for Laotian/Hmong was 1.6 times the white rate. In comparison to all groups, the risk of death during the first year of life was greatest for African Americans.

Relative to other reporting states and the District of Columbia, Wisconsin's infant mortality ranking has fallen since 1979-1981. In 1979-1981, relative to other ranked states, Wisconsin had the third lowest African American infant mortality rate. For the 2001-2003 period, Wisconsin ranked 39th out of reporting states and the District of Colombia, indicating it had the highest African American infant mortality rate. Since 1979-1981, Wisconsin's rank based on white infant mortality rates has also declined relative to other states, moving from a rank of 5 in 1979-1981 to 21 in 2000-2002. Thus, while Wisconsin's white infant mortality rate declined during the past two decades, improvement did not keep pace with many other states.

The infant mortality disparity of Blacks as compared to Whites ranked Milwaukee as the 4th worse among 16 U.S. cities (Big Cities Health Inventory, 2003).

2. Contraceptive Services

This priority takes into account the concerns voiced by many during the needs assessment process regarding unintended pregnancy, teen births, and abstinence from sexual activity. Our priority aligns with NPM #8 which examines rate of teen births. Wisconsin's new SPM #1 attempts to examine the access and utilization of contraceptive services by monitoring the percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

Women are defined as "in need of contraceptive services and supplies" during a given year if they are ages 13-44 and meet three criteria: 1) they are sexually active, that is, they have ever had intercourse; 2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized, and they do not believe that they are infecund for any other reason; and 3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.

Women are defined as "in need of publicly-funded contraceptive services and supplies" if they meet the above criteria and have a family income under 250% of the federal poverty level (estimated to be less than $42,625 for a family of four). All women younger than 20 who need contraceptive services and supplies are assumed to need publicly supported care, either because their personal incomes are below 250% of poverty or because of their heightened need--to preserve confidentiality--for obtaining care that not depend on their family's resources or private insurance.

640,420 women ages 13-44 are estimated to be in need of contraceptive services and supplies in Wisconsin. Ninety-three percent of females aged 15-44 years at risk of unintended pregnancy used contraception in 1995. Approximately 27% of the estimated need for public support family planning services has been met through the Medicaid Family Planning Waiver through March 2006.

3. Mental Health for All Population Groups

Mental health as a priority need links with the NPM #16 that focuses on deaths from suicide. Wisconsin's SPM #3 monitors the percent of children, ages 6 months -- 5 years, who have age

appropriate social and emotional developmental levels. (It is important to note that we recognize the importance of women's mental health, postpartum depression, the stigma associated with a mental illness diagnosis and adolescent indicators of need, however our SPM focus is on young children.)

According to the 2003 National Survey of Children's Health, 33 % of parents of young children, aged 0-5 years of age, have at least one concern about their child's learning, development or behavior and over 10% of children aged 3-17 are reported to have moderate or sever difficulties in the areas of emotions, concentration, behavior, or getting along with others. In addition, the 2005 National Health Interview Survey found 20% of boys and 12% of girls aged 4-17 years of age had parents who had talked to a health care provider or school personnel about their child's emotional or behavioral difficulties during the previous 12 months. Mental Health hospitalizations of children have increased from 4.7 per 1,000 children in 1997 to 5.5 per 1,000 children in 2003 according to the 2005 WisKids Count Data Book compiled by the Wisconsin Council on Children and Families, Inc.

4. Medical Home for All Population Groups

This priority need is an outgrowth of the NPM #3 which focuses on children with special health care needs; it also supports Wisconsin's new SPM #5 which maintains the focus on children with special health care needs and includes the priority of a dental home. The American Academy of Pediatrics believes that all children should have a medical home and as part of their focused priorities, the Wisconsin MCH Advisory Committee identified medical and dental home for all children. In addition, Wisconsin has been identified by MCHB as a Medical Home Leadership state.

A child with a medical home does not use a hospital emergency room as their primary place of care. According to the Wisconsin Family Health Survey in 2004, 1% of all children (under age 18) used the hospital emergency room as their primary place of care; among both Hispanic and white children, less than 1% used the emergency room as their usual place for care, while 5% of African American children did so. National SLAITS data indicate that: children without a medical home are twice as likely to experience delayed or forgone care; non-White children are significantly less likely to have a medical home; and poor children and children whose special health care needs have a significant adverse impact on their activity levels are more than twice as likely not to have a medical home and have unmet health care needs.

5. Dental Health (including CSHCN, racial/ethnic, linguistic, geography, income)

The dental health priority has shifted focus to access and accessibility. The NPM #9 concentrates on delivery of protective sealants whereas Wisconsin's new SPM #2 will observe the percent of Wisconsin Medicaid and BadgerCare recipients, ages 3-20, who received any dental services during the year.

Both Governor Jim Doyle, in his KidsFirst Initiative, and the state health plan, Healthiest Wisconsin 2010, identify oral health as a critical need. The National Survey of CSHCN reported that 83.1% of Wisconsin CSHCN required dental services and 92.6% received all needed dental services. 7.4% did not receive all needed dental services, which translates to 13,000 children with unmet oral health needs each year. The Wisconsin Family Health Survey revealed that 4.3% of CSHCN, or 12,800 children, did not receive needed dental care. The two primary reasons given were they couldn't afford dental care or had inadequate insurance.

In Wisconsin, 30.8% of children have at least one primary or permanent tooth with an untreated cavity. Compared to White children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of African American children, and 45% of Asian children, and 64% of American Indian children. In addition, children who attend lower income schools have

significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

6. Health Insurance and Access to Health Care

There is a strong relationship between health insurance coverage and access to health care. During the needs assessment process, our stakeholders had difficulty looking at one need without the other; thus, we combined them into one priority. The NPM #13 requires data on percent of children without health insurance. The Wisconsin SPM #6 monitors the movement to address this need by measuring the percent of children less than 12 years of age who receive one physical exam a year.

Wisconsin ranks high in the proportion of people who have health insurance. However, state data indicate that the maternal and child health population are less likely to be insured for the entire year. This presents opportunities for public health system partners to intervene at the individual, family and community-wide level and corresponds with the state health plan, Healthiest Wisconsin 2010. Within the state health plan, health insurance coverage is specifically delineated as key to whether or not health care services are likely to be sought and obtained.

7. Smoking and Tobacco Use

The Wisconsin continuing SPM #7 looks at percent of women who use tobacco during pregnancy. Smoking during pregnancy is a major risk factor for infant mortality, low birthweight, prematurity, stillbirth, and miscarriage. Overall in 2004, 14% of pregnant women in Wisconsin reported smoking during pregnancy; this rate is higher than the national rate of 10.2% (preliminary data 2004). In terms of racial differences, American Indian women continue to report the highest percentage of smoking during pregnancy, nearly 2.5 times as high as the overall state percentage.

8. Intentional Childhood Injuries

Discussions during the needs assessment process resulted in dividing injury into intentional and unintentional injuries. The NPM #16 relates to the priority as it addresses deaths from suicide among older teens. However, Wisconsin's new SPM #4 focuses on child abuse, neglect and maltreatment issues. We will monitor the number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.

In 2004, there were 42,451 total reports of child abuse and neglect with 8,600 substantiations in Wisconsin. This reflects a substantiation rate of 6.1 per 1000 of Wisconsin's children and youth between ages of ages newborn through 17 years. The largest number of substantiated reports (2,254) is for youth between the ages of 15 and 17 with 1,617 reported substantiations of sexual abuse.

9. Unintentional Childhood Injuries

The priority need for unintentional childhood injuries relates with the NPM #10 and the new SPM #10 both addressing death from motor vehicle crashes but for different age groups; 14 and under; and 15-19, respectively.

In Wisconsin, there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in the 0-19 age group. From 2000-2004, more than 1,600 children, teenagers, and young adults died from injuries (682 from motor vehicle-related injuries) and more than 31,000 were hospitalized; 51% of hospitalizations were caused by poisonings (19%), falls (16.8%), and motor vehicle-related injuries (16.4).

10. Overweight and At-Risk-for-Overweight

The concern about overweight and at risk for overweight was clear during the needs assessment process and surfaced as a priority need for Wisconsin. The priority need for overweight and at risk of overweight relates to the new NPM #14 and also NPM #11 (breastfeeding). Wisconsin's continuing SPM #8 also looks at the percent of children, 2-4 years who are obese or overweight.

The prevalence of overweight in Wisconsin children from age 2 to age 5 is 13.3%. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of at-risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 16.3% in 2004. In 2004, the highest rates for overweight and at-risk-for-overweight were among American Indian (20.5% and 22.6%), Hispanic (18.1% and 18.3%) and Asian (15.8% and 17.1%). Rates for Whites were slightly lower at 11.9% and 16.0%, and Blacks were at 10.7% and 14.3%.

/2007/ There were no significant changes in Wisconsin's ten priority needs. Our full 172 page document, including the Data Detail Sheets can be found as an attachment to Section II - Needs Assessment. //2007//

/2008/ These ten priority areas remain priorities as well as our State and National Performance measures. //2008//

/2009/ No significant change. //2009//

/2010/ The ten priorities identified in the last Needs Assessment process continue to be the priorities in addition to the Federal and State Performance Measures. As evaluation of progress toward the priorities occurred throughout the year, adjustments to the strategies and activities have been made. The specific changes in activities are reflected within the narrative for each of the applicable Performance Measures. It is anticipated that the Needs Assessment process begun this year will result in changes to the priorities which will be submitted next July with the 2011 application. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	124	117	119	106	118
Denominator	124	117	119	106	118
Data Source					WI St Lab Hyg 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2007
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2006
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

a. Last Year's Accomplishments
1. Newborn Screening--Population-Based Services--Infants

In 2008, 70,844 infants were screened for 47 different congenital disorders. 118 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care. Wisconsin was the first NBS program in the nation to screen for Severe Combined Immunodeficiency (SCID).

2. Diagnostic Services--Direct Health Care Services--Infants

The Department provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants.

The Education subcommittee initiated quarterly newsletters to birth hospital coordinators with regular updates and reminders about newborn screening.

The Immunodeficiency Subcommittee of the Newborn Screening Advisory group was established.

The Wisconsin NBS Program continued to participate in the HRSA "Region 4 Genetics Collaborative" grant with Wisconsin representatives in all workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening			X	
2. Diagnostic Services	X			
3. Development of Educational Materials		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Newborn Screening--Population-Based Services--Infants

The Wisconsin NBS Program currently screens all infants for 47 congenital disorders.

The Newborn Screening Coordinator within the Division of Public Health works with the contracted agencies to promote and improve the NBS Program through the establishment and evaluation of performance-based objectives. Work with the contract agencies includes the coordination and tracking of nutritional products for congenital disorders patients. The NBS Coordinator organizes the biannual NBS Advisory Group and Subcommittee Meetings and provides ongoing communication to birth hospital coordinators through the disbursement of quarterly newsletters and mailings of the Wisconsin Newborn Screening Brochure.

The NBS Program is working with the Wisconsin Hearing Screening Program, Vital Records, and the Birth Defects Surveillance System to explore linking newborn screening data with other birth data.

c. Plan for the Coming Year

1. Newborn Screening--Population-Based Services--Infants

In 2009, all infants born in Wisconsin will continue to be screened at birth for a minimum of 47 congenital disorders.

The NBS Advisory Group and its Cystic Fibrosis, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, and Education subcommittees will meet at least biannually to advise the Department regarding emerging issues and technology in NBS.

2. Diagnostic Services--Direct Health Care Services--Infants

The Department will continue to implement a paper-based tracking system for NBS dietary services in preparation for a web-based system. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for by NBS by dieticians at contracted specialty centers. Performance based contracts will be reviewed and revised to continue to promote Medical Home implementation strategies such as care coordination and transition planning.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants

The NBS Advisory Group Education subcommittee will continue to educate the public and medical providers about Severe Combined Immunodeficiency (SCID). The subcommittee will continue to improve communication with the NBS program and hospitals through e-newsletters and other means. The subcommittee will continue to develop a module for childbirth educators about newborn screening to be presented to parents-to-be during childbirth education classes. The subcommittee will use a newly created NBS DVD as an education piece in a variety of settings to educate about Newborn Screening.

The NBS program will work with the Region IV Genetics Collaborative to share their web-based programming with Wisconsin partners. A link to the Guide for Families developed by the Medical Home Education Workgroup will be shared with families and health care providers when available on the Region IV website.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	68.6	69.6	70	70.5	71
Annual Indicator	66.6	66.6	65.3	65.3	65.3
Numerator	47819	47819	132074	132074	132074
Denominator	71816	71816	202257	202257	202257
Data Source					SLAITS CSHCN.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	71.5	72	72.5	71	71

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1. Family Support Services--Enabling Services--CYSHCN

In 2008, the following services were provided: 86 families were matched through the WI Parent to Parent Program; 78 families received health education through Family Voices of WI (FVW)/Family to Family Health Information Network; and 1,309 families received individual information and assistance through the five Regional Centers for CYSHCN and their subcontracted agencies, which enhanced the capacity of parents to be decision makers, supported partners as leaders and offered parents an avenue to develop an informal network of support. In collaboration with the MCB Integrated Services grant (WISC-I, ended April 30, 2008), * families with complex health benefits challenges received intensive health benefits counseling from ABC for Health, a non-profit health and advocacy firm in Madison.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2008, the CYSHCN Program contracted with FVW to provide: a newsletter, which is distributed both electronically and hard copy, three times per year, and went out to 850 individuals; technical assistance to Regional Centers; policy updates and notifications of opportunities for involvement in a variety of issues, which went to about 150 individuals; and health benefits training targeting CYSHCN from under-represented populations. The outreach to underserved populations resulted in non-English speaking families receiving both Parent to Parent and Family Voices trainings and materials in Spanish.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continued to be utilized in a variety of advisory capacities including a listening session for parents at the annual Circles of Life Conference. At the 2008 Conference, FVW received feedback from parents on the question "What would you change to improve community supports and services, health care, coordination between programs, and education for families?" FVW used information gathered from this listening session to inform its work as well as the State's MCH Program with policy makers to improve care and coverage for CYSHCN. Also, each Regional Center and FVW supported parents to be linked to councils at the local, regional and state levels. The staff at the Regional Centers, FVW and Parent to Parent all serve on a range of councils and committees to advance the performance measure to address families as partners in decision-making at all levels.

In 2008 the CYSHCN Program was awarded a MCHB-Combating Autism Act Initiative State Implementation grant. As part of this initiative, a Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities was established with a parent of a young child with Autism Spectrum Disorder as Co-Chair of the Community of Practice. Participants in the Community of Practice include a number of parents and parent organizations, and a Practice Group on Parent Supports is being established. FVW, Parent to Parent, and the Regional Centers for CYSHCN are all members of the Community of Practice.

Wisconsin also had a family delegate on the AMCHP Family and Youth Leadership Committee in 2008. That person participates on the national AMCHP Committee as well. Preliminary work was done to involve more families in AMCHP.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2008, parents of CYSHCN were part of the staff of the State CYSHCN Program, all five Regional Centers, Parent to Parent and FVW, making parents integral to the ongoing decision-making, program implementation and evaluation. CYSHCN partners have formed a Collaborators Network which communicates regularly to share resources, problem solve difficult issues and identify unmet needs in the state. A subgroup of the Network consists of staff providing information and referral services to families and this group holds monthly teleconferences and has a listserv to increase the level of communication. FVW tracks policies that impact families

and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers resulting in new funding for long term care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Services		X		
2. Coordination with Family Leadership and Support			X	
3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program				X
4. Family Partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Family Support Services--Enabling Services--CYSHCN

In 2009, families receive parent matching, training, information and assistance.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2009, the CYSHCN Program contracts with FVW to provide: a newsletter three times per year; listserv; policy updates; and health benefits training for under-represented populations including Great Lakes Inter-Tribal Council's (GLITC) parents.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continue to be utilized in a variety of advisory capacities including: Parents on the Community of Practice for Autism Spectrum Disorders and other Developmental Disabilities; and parents serving as advisors to the Newborn Screening Program, Wisconsin Sound Beginnings, Birth Defects and Surveillance Program, and MCH Advisory Committee. FVW also works with each Regional Center for CYSHCN to identify and strengthen parent leaders.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2009 parents continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network met in April to share experiences and best practices related to reaching families of diverse and harder to reach cultures. FVW tracks policies that impact families and is effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers.

c. Plan for the Coming Year

1. Family Support Services--Enabling Services--CYSHCN

In 2010, families will continue to be matched through the WI Parent to Parent Program, receive health education through FVW, and be offered information and assistance through the Regional Centers. Families will continue to be members of the Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities and the Community of Practice on Transition.

Both groups have family members in leadership roles and include practice groups on parent supports.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2010 the CYSHCN Program will continue to contract with FVW and dovetail these activities with those of the Family to Family Health Information Network grant that FVW has through MCHB. FVW will provide: a newsletter three times per year; health benefits training targeting CYSHCN from under-represented populations; data collection, analysis and dissemination of unmet needs; and assistance in Regional Center transition to adult health care trainings. FVW will continue to build a parent network with these activities. Outreach to underserved populations will continue to target African American and Native American families through established cultural brokers. Parent to Parent will continue to work with the Southeast Regional Center and Alianza, an organization that works with Latino families of CYSHCN, to reach out to the Latino CYSHCN population in Southeastern Wisconsin. Non-English speaking families will be trained to be Parent to Parent support parents and efforts will be made to identify non-English speaking match parents.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents will continue to be utilized in a variety of advisory capacities through Regional Centers and Family Voices who support parents to be linked to a council or committee at a local, regional, or state level. The staff at the Regional Centers, FVW and Parent to Parent will continue to serve on a range of councils and committees to advance the performance measure on parents as decision makers.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2010, parents will continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network will meet annually in person and by phone so the CYSHCN system for building parents as partners can be coordinated across programs. The Information and Referral group will continue with regular contact so that staff understand the ever-changing health benefits system and can educate families about community resources and benefits eligibility. FVW will continue to track unmet needs in collaboration with CYSHCN partners so that family needs are articulated on a policy level.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	59.1	60.1	60.5	61	55
Annual Indicator	57.1	57.1	54.6	54.6	54.6
Numerator	98758	98758	110432	110432	110432
Denominator	173017	173017	202257	202257	202257
Data Source					SLAITS CSHCN.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	57	58	59	60	60

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1. Medical Home Education and Training--Population-Based Services--CYSHCN

Medical Home Toolkit was disseminated using a variety of methods, including face-to-face presentations at primary practice offices and at variety of meetings with different stakeholder groups.

The Program also included promotion of best practice, evidence-based developmental screening within context of a medical home. In partnership with Regional Centers and the UW-Waisman Center, 14 primary care providers were recruited who will serve as trainers to spread implementation of Ages and Stages Questionnaire developmental screening tool.

2. Medical Home Outreach--Population-Based Services--CYSHCN

As part of Spread, dissemination of concepts of Medical Home continued to be integrated in Wisconsin Sound Beginnings (Early Hearing Detection and Intervention) and Congenital Disorders (blood spot newborn screenings) Programs. Medical Home Local Capacity Building grants, administered by each CYSHCN Regional Center, were in the first year of their second cycle. We created and issued a RFP to fund local communities to support local implementation of medical home. These ten local capacity grants targeted underserved populations such as racial and ethnic populations and rural areas. The Medical Home Toolkit website, http://wimedicalhometoolkit.aap.org/toolkit/index.cfm, during the sampling period from August - November 2008, had: 7,717 total visitors; 431 average hits per day; 63 average visitors per day; 5,662 total file downloads; and 11,318 total page views.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

CYSHCN Regional Centers continued to develop relationships with individual providers in their region to assist with community connections, information and referrals. The State CYSHCN Program continued its collaborative efforts with Division of Health Care Access and Accountability. A Medical Home Practice Group was also created in conjunction with Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Education and Training			X	
2. Medical Home Outreach			X	
3. Medical Home and Community Supports				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Medical Home Education and Training--Population-Based Services--CYSHCN

The CYSHCN Program is implementing improvements to its Medical Home Toolkit to include closed captioning of videos and feedback from evaluations. FVW and Regional Centers for CYSHCN continue to integrate Medical Home concepts and strategies into their information-sharing and training.

2. Medical Home Outreach--Population-Based Services--CYSHCN

Medical Home Local Capacity Building Grants, administered by each Regional Center, are in the second year of the second cycle and grantees will meet to learn more about Medical Home and exchange information and strategies. Medical Home spread activities continue to dovetail with other CYSHCN initiatives to maximize spread.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

Physicians recruited in 2008 were trained to train other physicians in implementation of the ASQ developmental screening tool in context of medical home. Trained physicians can now train others across the state. The trainings are in partnership with the Regional Centers and local Birth-3 Programs. The Regional Centers also continue to reach out to new providers in their regions to assist with community connections, information and referrals. The CYSHCN Program partners with the Medical Home Learning Collaborative so that lessons learned and products developed are shared with partners and included in the Toolkit.

c. Plan for the Coming Year

1. Medical Home Education and Training--Enabling Services--CYSHCN

The CYSHCN Program will maintain and update its Medical Home Toolkit as needed. The State CYSHCN Program will continue to work with Wisconsin Academy of Family Physicians and Wisconsin Chapter of the American Academy of Pediatrics to promote concept of medical home for CYSHCN and foster its growth and spread in communities across the state. Staff will maintain connections to a variety of medical home activities around the state to continue to keep the needs of CYSHCN as a focus, and will work to influence stakeholder groups as Wisconsin continues to move toward patient-centered medical home implementation. We will work to maintain our presence and influence regarding CYSHCN and medical home.

2. Medical Home Outreach--Population-Based Services--CYSHCN

The State CYSHCN Program will be pursuing a mini-grant process for one year of funding. These mini-grants will continue and build on our efforts to support practice-based developmental

screening and other medical home implementation strategies for CYSHCN. These will continue to function as a partnership between the State program and our Regional Centers for CYSHCN. Dollars will also be earmarked to continue our support of community and family involvement in the Latino community in SE Wisconsin.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The State CYSHCN Program and its contracted agencies will continue to promote Medical Home spread and offer technical assistance supports through work with key partners on the local, regional and state levels. Promotion will include targeting children's hospitals and pediatric units within hospitals; primary care practices; local health departments; state and community partners; and parents of CYSHCN. Regional Centers are reaching out to new providers in their regions to assist with community connections, information and referrals. The CYSHCN Program partners with the Medical Home Learning Collaborative so that lessons learned and products are shared with partners and included in the Toolkit.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	67.6	68.6	69	69.5	64
Annual Indicator	66.6	66.6	63.0	63.0	63.0
Numerator	117664	117664	127442	127442	127442
Denominator	176641	176641	202257	202257	202257
Data Source					SLAITS CSHCN.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	66	67	68	68

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

1. Health Benefits Services--Enabling--CYSHCN

The Regional Center network continued to receive health benefits training via webcasts which are archived and available for viewing. The Regional Centers and Family Voices of Wisconsin (FVW) have joined ABC for Health's HealthWatch group. Parent trainers of FVW continued to offer family members training regarding health insurance and community supports with the support of the Regional Centers for CYSHCN.

2. Access to Health Insurance--Infrastructure Building Services--CYSHCN

The Regional Centers continued one of their core services in assisting families to secure health insurance through information, referral and follow-up.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

In 2008 the Oral Health Program continued to provide technical assistance and program guidance to the Children's Health Alliance of Wisconsin (CHAW). CHAW is the program monitor and administrator for a grant written by the Oral Health Program to provide didactic and clinical training to dental health professionals in an effort to increase their knowledge and skills with the treatment of CYSHCN. During 2008 there was one comprehensive training held with 211 oral health professionals attending, including 31 DDS, 161 RDH's and 18 DA's. Additionally, the grant supports 6 regional oral health consultants who provide technical assistance, case management and follow up care to families of CYSHCN.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

DHS has finalized the Infant Mental Health Leadership Team 2008 Annual Report. This report helps address the Governor's Kids First Initiative supporting Infant and Early Childhood Care. Wisconsin Medicaid has adopted the DC:0-3 R diagnostic classification system. The Bureau of Mental Health contracted with Wisconsin Alliance for Infant Mental Health to conduct a series of trainings for providers on the DC: 0-3 R to assist in diagnosis and billing.

The Wisconsin Infant Mental Health Leadership Team and Children's Mental Health Committee of the Wisconsin Council on Mental Health continue to address the issues of mental health screening in primary care, and shortage of child and adolescent psychiatrists. Wisconsin, while near average, was still 1 of 35 states with less than the national average of psychiatrists for its youth population. The modeled number of psychiatrists for optimum care was reported as 14.38 per 100,000 youths, while Wisconsin reported 8.2 per 100,000.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Health Benefits Services		X		
2. Access to Health Insurance				X
3. Access to Dental Care Services				X
4. Mental Health Services for CYSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Health Benefits Services--Enabling--CYSHCN

We continue to partner with ABC for Health and ABC for Rural Health.

2. Access to Health Insurance--Infrastructure Building--CYSHCN

BadgerCare Plus, for low income childless adults without health insurance begins July 2009. This benefit will insure men and women age 18 and older who currently do not qualify for Medicaid. For those with a disability and are unable to obtain insurance, this benefit may help close part of the insurance coverage gap. Wisconsin has a pending Bill on Autism Insurance coverage.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

DHS continues to provide technical assistance and guidance to CHAW. In 2009 there have been 2 didactic and one clinical training held for oral health professionals, targeting treatment concerns related to CYSHCN. Training evaluations show marked increase in knowledge, skills and comfort level treating CYSHCN.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

DHS has notified day treatment providers about Positive Behavioral Supports-Seclusion and Restraint Use. The WI Infant Mental Health Leadership Team and the Children's Mental Health Committee of the WI Council on Mental Health continue to address the issues of mental health screening in primary care and the shortage of child and adolescent psychiatrists.

c. Plan for the Coming Year

1. Health Benefits Services--Enabling--CYSHCN

We plan to continue to partner with ABC for Health and participate in HealthWatch.

2. Access to Health Insurance--Infrastructure Building--CYSHCN

The Regional Centers will continue one of their core services in assisting families to secure health insurance through information, referral and follow-up. Through the WIC/CYSHCN Network, we will continue to problem-solve access to nutritional services for CYSHCN.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

The Department will continue to provide CHAW with technical assistance and guidance related to grant activities to increase the knowledge and skills of dental health providers in the treatment of CYSHCN. There are plans for at least 3 training sessions in various regions across the state. We will be specifically targeting CHC's and FQHC's for program attendance and on-site, ongoing technical support.

4. Access to Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The following goals will be addressed through the Children's Mental Health Committee. Expand collaborative systems of care (i.e., wraparound), with a goal of children's wraparound systems in each of Wisconsin's 72 counties within 6 years. Create financial incentives to increase family advocacy and support for counties with a Coordinated Services Team (CST) initiative. Increase mental health early intervention activities directed toward children and youth. Increase children's mental health training and available consultation for teachers and preschool/daycare providers. Take steps to increase the availability of qualified mental health providers throughout Wisconsin, particularly in underserved areas.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	82.7	83.7	84	84.5	91
Annual Indicator	80.7	80.7	90.0	90.0	90.0
Numerator	57768	57768	182031	182031	182031
Denominator	71620	71620	202257	202257	202257
Data Source					SLAITS CSHCN.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	91	92	92	93	93

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1. Access to Individual/Household Services--Enabling Services--CYSHCN

Individuals, families, and providers who contact the 5 CYSHCN Regional Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2008, according to data entered in the SPHERE, there were 3,604 CYSHCN-funded contacts and services provided, with 1,309 individual/household interventions and 2,295 brief contacts. "Brief contacts" include consultations that are face-to-face, on the telephone, and/or in writing.

2. Community Based Services--Population-Based Services--CYSHCN

Partnerships at the local, regional and state levels were advanced through co-sponsored events, established cross-referral plans and collaborative efforts to serve identified target populations.

The CYSHCN Program and its Regional Centers have delineated key committees and conferences where CYSHCN representation is critical and an outreach plan specifies responsibilities over the state.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

There is an established Collaborators Network, and the CYSHCN Program continues to work collaboratively with many partners to assure that CYSHCN are identified early, receive coordinated care, and that their families have access to the supports they need. These collaborative partnerships include: Parent to Parent; FVW; Great Lakes Inter-Tribal Council; ABC for Health and ABC for Rural Health; First Step; Wisconsin Chapters of the AAP and WAFP; Early Intervention ICC; Wisconsin Early Childhood Collaborating Partners; Department of Public Instruction's Wisconsin Statewide Parent-Educator Initiative; the Parent Training and Information Center - WI FACETS; statewide Wisconsin Asthma Coalition; Wisconsin Infant Mental Health Association; and the Circles of Life Planning Conference.

Working in partnership with other funding sources, the state CYSHCN Program has established a network of 9 WIC nutritionists who work with the Regional Centers to improve nutritional services for CYSHCN. They meet regularly and are also part of the Collaborators Network.

Wisconsin was awarded a MCH Targeted Oral Health Service Systems Grant entitled "Wisconsin Community-based System of Oral Health for CYSHCN." This four-year grant is administered through the Children's Health Alliance of Wisconsin. They are part of our Collaborators Network and did trainings for providers regarding oral health and CYSHCN around the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access to Individual/Household Services		X		
2. Community Based and System Based Services			X	
3. Planning and Implementing Community Based Projects				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Access to Individual/Household Services--Enabling Services--CYSHCN

In 2009, the 5 Regional Centers and their delegate agencies continue to provide information and assistance to families and providers. LHDs continue to have the option of providing these services at a local level. Families are linked to trainings and parent support opportunities to meet their needs.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

Regional Centers for CYSHCN administer 10 Medical Home local community capacity grants allowing communities to build upon assets and develop local systems of care for CYSHCN.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--

CYSHCN

The Regional Centers meet with the regional oral health consultants from the Wisconsin Community-based System of Oral Health for CYSHCN. Centers also continue to access their WIC-nutrition regional consultants who also are working with their LHDs.

Regional Centers continue to respond to local requests for training, outreach and assistance. The Collaborators Network continues to share resources, problem-solve, and cross-refer.

c. Plan for the Coming Year

1. Access to Case Management, Consultation and Referral and Follow-up Services--Direct Health Care Services--CYSHCN

In 2010, the 5 Regional Centers for CYSHCN and their delegate agencies will continue to provide information and assistance to families and providers. Families will be linked to trainings and parent support opportunities to meet their needs. The LHDs will again have the option to choose serving CYSHCN through Regional Center subcontracts and/or MCH Consolidated Contracting.

CYSHCN staff will begin planning for the next five-year cycle based on outcomes from a MCH needs assessment that is occurring in 2009. We will do this in collaboration with our partners and members of our Collaborators Network.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

Regional Centers will continue to be involved in building local medical home capacity across the state through the use of mini-grants. Because a new cycle will begin in January 2011, these will be one-year grants instead of two and will be mini-grants. Most importantly, we will begin to plan for the next cycle based upon the results of the needs assessment.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects in 2010: continue to implement the Regional Center for CYSHCN model; use the statewide GAC system to manage and monitor the objectives and fiscal operation of the CYSHCN Program; and provide technical assistance to recipients of local community capacity grants to monitor, evaluate and support the objectives of the grant. The Collaborators Network will continue to share resources, problem-solve, and cross-refer.

The CYSHCN Program will continue to work to increase our program's visibility, focus more attention on early identification and screening and broaden the stakeholder group that meets regularly. We will continue to market our program and our collaborators as a network through common marketing themes and the use of common design elements in our materials.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	7.8	7.8	8	7	50
Annual Indicator	5.8	5.8	44.5	44.5	44.5

Numerator	64727	64727	90004	90004	90004
Denominator	1116374	1116374	202257	202257	202257
Data Source					SLAITS CSHCN.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52	54	55	56	56

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
Data issues: 1)The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2)We revised our objectives for 2007 - 2011 to realistically assess this measure; however, Wisconsin does not have state-specific data for this measure and we rely on SLAITS.

a. Last Year's Accomplishments
1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program continued to support the Community of Practice on Transition (CoT) in collaboration with DPI. The Regional Centers continued to support transition activities at the local and regional level through their involvement in the CoT and practice teams on CYSHCN-specific areas. The CYSHCN Program lead the Practice Group on Health. While WISC-I ended in April of 2008, the CYSHCN Program sustained integration initiatives through Regional Center contracts and state managed activities. The state was on the steering group for the statewide CoT. The Medical Home Transition Learning Collaborative with youth, families, tertiary care providers, and administrators came to a close and outcomes from that work on transition from pediatric to adult care services was disseminated. The collaborations continue through regional and state partnerships.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

A CoT workgroup adapted the Pennsylvania Health Care Checklist for use in WI. The original

HRTW Transition to Adult Health Care training curriculum was reviewed by key stakeholders and was revised with support from additional funding sources. Members of the Practice Group on Health presented the checklist at the annual WI Transition Conference.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program continued to disseminate quality information about transition to families and providers. Regional Centers answer calls directly from families about transition and two local capacity grantees addressed transition through youth training and a newsletter from a primary care practice.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State Partnership Building				X
2. Training (IB) and Outreach (PBS)			X	X
3. Access to Transition Information		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program continues to support the Community of Practice on Transition (CoT) in collaboration with Department of Public Instruction. This collaborative group has representatives from over 40 state programs and community partners with transition-related interests. The state CYSHCN Program is part of the core leadership team for the CoT. The Regional Centers for CYSHCN continue to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas. In February 2009, the CYSHCN Program sponsored an annual CoT meeting with a focus on health. The Health Care Checklist was finalized, printed and disseminated to key stakeholders, including posting it on the WI Medical Home Toolkit and sharedwork.org websites.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The Transition to Adult Health Care curriculum was printed and disseminated to further prepare YSHCN, their families and providers for the move from pediatrics to adult health care. The Regional CYSHCN Centers and Family Voices parent trainers received a train-the-trainer session on the revised Health Care Transition curriculum. Following this training, there will be opportunities for youth, parents, and providers to go to a training and receive targeted support in a clinical or one-to-one setting.

c. Plan for the Coming Year

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program will continue to support the Community of Practice on Transition in collaboration with the Department of Public Instruction. The state CYSHCN Program is part of

the core leadership team for the CoT. The CYSHCN Program was awarded a Statewide Implementation Grant for Autism Spectrum Disorders (ASD) and has begun to create a Community of Practice on ASD and other developmental disabilities. Plans are under way to align the two Community of Practice groups. The CYSHCN Program utilizes sharedwork.org to catalogue information and resources for this Community work. As an example, at the 2009 CoT a mother and her young adult son spoke about the health care transition in moving from home to college. The young man has Asperger syndrome, so plans for this presentation to be broadly disseminated to the CoP ASD group are underway. The Regional CYSHCN Centers will continue to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas. In 2010, the CYSHCN Program will sponsor an annual CoT meeting with a focus on health. The Health Care Checklist will continue to be disseminated to key stakeholders, including a session at the annual statewide transition conference for professionals and parents, and through the Family to Family Health Information Center.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The Transition to Adult Health Care curriculum will be further disseminated to prepare YSHCN, their families and providers for the move from pediatrics to adult health care. The Regional CYSHCN Centers and Family Voices will disseminate this information and the My Health Pocket Guide to youth and their families.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	83	83.5	83.2	83.4	83.5
Annual Indicator	83.0	83.0	82.3	79.3	79.3
Numerator	730	730	724	349	349
Denominator	880	880	880	440	440
Data Source					CDC Nat Imm Surv 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83.6	83.7	83.7	83.7	83.7

Notes - 2008
The data entered for 2008 are from the National Immunization Survey for CY 2007. For Wisconsin children 19-35 months of age who had received 4 DTaP, 3 polio,1 MMR,3 Heb b and 3 Hib vaccine doses, the estimate was 79.4% with confidence intervals plus or minus 6.4%. Although the 2007 survey's immunization rate estimate for Wisconsin is slightly lower than the 2006 estimate, the difference is not statistically significant. Also, in prior survey years, large urban areas in 15 states (inc. Wisconsin) were over-sampled. When this aspect of the sampling methodology was discontinued in 2007, 14 of these states (inc. Wisconsin) experienced lower

rate estimates. While the precise effect of the methodological change is unknown, overall study results suggest a potentially negative impact.

Notes - 2007
The 2007 data from the National Immunization Survey show that Wisconsin's immunization estimated coverage rates for 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib among kids 19-35 months of age rose from 83.0% in 2005 to 86.8% in 2006. This increase may be due to acceptance and use of the Wisconsin Immunization Registry (WIR).

Notes - 2006
Data issues: The most recent data from the CDC is from the National Immunization Survey (www.cdc.gov/nip under "data and statistics" and represent calendar year 2005. The vaccine coverage estimates for 2005 among Wisconsin children who were 19 to 35 months of age with 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib doses was 82.2%. This is a slight decline from last year's estimate. The NIS states: "Remember, NIS provides estimates that include a margin of error. That's because it is a sample survey. Even though the sample is quite large -- about 30,000 children (nationally), it is just one of many possible samples. A different sample would result in a different--but probably quite similar estimate. The drop could be due to chance." Although the national goal for 2010 is 90%, we have kept our 2010 and 2011 objectives at the same level based on program expertise.

a. Last Year's Accomplishments
1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

The National Immunization Survey (NIS) provides estimates of preschool immunization coverage. The latest full year's data from the NIS (minus the dose of varicella) shows that Wisconsin's immunization estimated coverage rates among kids 19-35 months of age for series complete (4DTap, 3 Polio, 1 MMR, 3 Hepatitis B and 3 Hib) declined from 86.8% in 2006 to 79.4% in 2007. In prior survey years, large urban areas in 15 states (including Wisconsin) were over-sampled. When this aspect of the sampling methodology was discontinued in 2007, 14 of these states (including Wisconsin) experienced lower rate estimates. While the precise effect of the methodological change is unknown, overall study results suggest a potentially negative impact.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

The State Immunization Program continued to partner with the Title V MCH/CSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs. The WIR supports and maintain WIC sites as registry program participants.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in subsequent policy changes or clinical practices are tracked by the State Immunization Program. Information updates were shared by the state Immunization Program with key partners as indicated via email and at spring communicable disease seminars held in each of the five DPH regions.

4. Quality improvement of Vaccines for Children program--Infrastructure Building Services--Children, including CYSHCN

QI efforts for providers in 2008 occur through site visits by Immunization Program personnel to 25% of all VFC sites in Wisconsin. One of the topics covered is provider participation with the

WIR and the appropriate use of the reminder/recall function. The performance based contract template objective for local health departments is to raise immunization levels of all preschool children within their service areas. The CDC goal is 90% series complete (4 DTaP, 3 Polio, 1 MMR, 3 Hepatitis B, 3 Hib and 1 varicella) by 24 months of age. The Wisconsin Immunization Registry (WIR) benchmark reports are used to measure this objective.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing, Monitoring, and Assuring Immunizations	X			
2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)				X
3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program				X
4. Quality Improvement of Vaccines for Children Program				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V funding continues to support LHDs primary prevention activities that include immunization monitoring, and support compliance with State Immunization Program funds.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

The State Immunization Program continues to partner with the Title V MCH/CSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule are tracked by the State Immunization Program.

4. Quality improvement of Vaccines for Children program--Infrastructure Building Services--Children, including CYSHCN

The performance based contract template objective for local health departments is to raise immunization levels of all preschool children with in their service areas. The CDC goal is 90% series complete (4 DTaP, 3 Polio, 1 MMR, 3 Hepatitis B, 3 Hib and 1 varicella) by 24 months of age.

c. Plan for the Coming Year

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V, MCH program funding will continue to support LHDs' primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funding requirements. Data required enabling MCH to monitor and report this measure will continue to be provided by the state Immunization Program.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

State Immunization Program will continue to partner with Title V MCH/CSHCN Program, LHDs, WIC Program, Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule will continue to be tracked by the State Immunization Program during 2010 with policy sharing will occur as appropriate.

4. Quality improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

During 2010, quality improvement efforts for providers will be maintained through site visits by staff in the State Immunization Program.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15.4	15.1	14.8	14.7	14.9
Annual Indicator	14.9	14.9	15.6	16.0	16.0
Numerator	1765	1776	1840	1874	1874
Denominator	118370	119124	118012	117042	117042
Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.1	16.1	15.9	15.9	15.8

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Data notes: There were 80 births to teen <15 years in Wisconsin in 2007. Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/7/2009.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Population Module, accessed 03/21/2009.

Notes - 2006
Data notes: There were 92 births to teen <15 years in Wisconsin in 2006. Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/7/2008.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Population Module, accessed 03/21/2007.

a. Last Year's Accomplishments
1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

The MAPPP provided data on their Wisconsin Family Planning Waiver efforts among 15 to 19 year old Milwaukee African American adolescents. The data was presented to the Division of Public Health management and it offered further evidenced of the disparities for both teen births and STDs. The MAPPP was enhanced by the addition of Milwaukee Keenan Health STD Clinic. This clinic serves a large number of clients and has begun to sign up clients on the Waiver and make referrals to other MAPPP members.

2. Data--Infrastructure Building Services--Adolescents

The Bureau of Health Information and Policy completed work for the fourth edition of the Joint DPI-DHS Wisconsin Youth Sexual Behaviors Outcomes Data Report highlighting trend data for abstinence, HIV/STD and teen births.

3. State Adolescent Pregnancy Prevention Committee--Population-Based Services--Adolescents

The Department of Health and Family Services completed a statewide press release to promote May as National Teen Pregnancy Prevention Day and Month.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Milwaukee Adolescent Pregnancy Prevention Partnership		X		
2. Data				X
3. Statewide Adolescent Pregnancy Prevention Committee			X	
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services-A-dolescents

The MAPPP established project goals focusing on social marketing outreach and FPW enrollment based on input from teen focus groups.

2. Data-I-nfrastructure Building Services--Adolescents

The fourth edition of the Joint DPI-DHS Wisconsin Youth Sexual Behaviors Outcomes Data Report was published in January 2009. The result of this report was shared with the DHS Secretary Office because the results reflected significant disparities in the area of HIV, STD and teen births. End product led to the policy and program recommendations to better address these disparities

3. Dual Protection Project--Population-Based Services--Adolescents

A dual protection project was integrated into the Milwaukee STD clinic: dual intervention to reduce unintended pregnancy as well as STD. This project serves a population at extremely high risk of unintended pregnancy. Dual protection is being established as a standard of care.

Another project, called "Women's Health Now and Beyond Pregnancy" focuses on intervention to ensure that post-partum contraceptive plans are developed in the third trimester of pregnancy, and supplies and/or contraceptive arrangements are in place prior to delivery. PNCC participants are served through this program and are at high risk of a subsequent unintended pregnancy. Healthy pregnancy spacing is emphasized as an important consideration as part of one's reproductive plans.

c. Plan for the Coming Year

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

The MAPPP will provide mid-year reports on the progress of their social marketing campaign and explore the data significance of the increase in teen pregnancies for the 18 to 19 year old population as a way to streamline the Partnership's outreach efforts

2. State Adolescent Pregnancy Prevention Committee (APPC)--Population-Based Services--Adolescents

The State APPC, led by the Department of Health Services, the Department of Children and Families and the Department of Public Instruction plans to examine the results of a 2009 statewide survey of the members of the Wisconsin Adolescent Sexual Health Listserv to determine the future direction of the committee.

3. Dual Protection Project--Population-Based Services--Adolescents

Services implemented by the Women's Health Now and Beyond Pregnancy project will be integrated into Reproductive Health/Family Planning, MCH and PNCC programs. These services

assure that pregnant and postpartum women have access, prior to delivery, to a primary method of birth control, EC as a back-up method and condoms for dual protection against pregnancy and STIs. These services will be promoted to local health departments and PNCC providers. Subsequent unintended pregnancy rates in Milwaukee are very high. The PNCC population is vulnerable to subsequent unintended pregnancy, and to the social, economic, and health consequences of a subsequent unintended pregnancy and a short inter-conceptional interval.

4. Family Planning Waiver--Infrastructure Building Services--Adolescents

The Wisconsin Medicaid Family Planning Waiver will be promoted and recent enrollment policies will simplify the enrollment process. Increased access to services and supplies will be promoted as a program priority and incorporated into contract performance expectations.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	49.5	50	50	50	50
Annual Indicator	47.0	47.0	47.0	47.0	50.8
Numerator	34134	34134	34134	34134	35806
Denominator	72626	72626	72626	72626	70484
Data Source					WI DHS/DPH 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	51	51	52	52	53

Notes - 2008
Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353.

Notes - 2007
Source: Numerator: calculated by taking 2001's indicator, the Wisconsin Division of Public Health"Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. We are currently conducting another third grade survey, therefore, for next year we will have updated information/data.

Notes - 2006
Source: Numerator: calculated by taking 2001's indicator, the most recent Wisconsin Division of Public Health"Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. Future data are dependent on funding for an additional survey.

a. Last Year's Accomplishments

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Heath Care Services--Children

The Wisconsin Seal-A-Smile statewide school-based, school-linked dental sealant program provided grant funding of nearly $200,00 to 21 local health departments and community-based agencies. In 2007/08 school year, the 21 Seal -A-Smile projects held 200 events, screened 9,860 children and provided 24,831 dental sealants to 6,254 children. The Seal-A-Smile program average for sealant placement per child was $21.20, however the cost per cavity averted, according to the Centers for Disease Control and Prevention health economists is $51.48. The Oral Health Program continued to contract with the Children's Health Alliance of Wisconsin to administer and monitor the Seal-A-Smile program.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

In 2008 the Wisconsin Oral Health Program was the recipient of a CDC Cooperative Agreement award. The award is designed to increase capacity and build infrastructure to ensure Wisconsin has an adequate oral health workforce to successfully address statewide needs. The award allows for the the creation of a Dental Sealant Coordinator position to enhance and expand the program.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance was provided to the 21 statewide grantees primarly in cooperation with the Children's Health Alliance, Oral Health Program Manager. The State Chief Dental Officer and the State Public Health Dental Hygienist monitored grantee contracts and provided technical support.

4. Oral Health Surveillance--Population Based Services--Children, including CYSHCN

In 2008 the Wisconsin Division of Public Health Oral Health Program conducted its second "Make Your Smile Count Survey" oral health assessment of third grade students. The total sample of children evaluated was 4,355. The survey data revealed that 50.8% of Wisconsin third grade students had evidence of dental sealants on at least one permanent tooth, exceeding the Healthy People 2010 objective for sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program	X			
2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support				X
3. Technical Assistance		X		
4. Oral Health Surveillance			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Healthy Smiles for Wisconsin Seal-A-Smile (SAS) Sealant Program--Direct Heath care Services--Children

Currently the Seal-A-Smile program provides nearly $200,000 in funding to support 21 grantee projects. The DPH Oral Health Program is awaiting final decision on a grant application submitted to the HRSA to nearly triple funding to the SAS statewide school-based, school-linked dental sealant program.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

We are in the final processes of hiring a Dental Sealant Coordinator who, after training, will be instrumental in expanding the Seal-A-Smile program. Maternal Child Health Block Grant funding was provided to 5 local agencies to provide oral health assessments and sealant placement. In 2009 our partner and grant monitor for the SAS program, The Children's Health Alliance of Wisconsin worked with Delta Dental to publish an extensive report "Partnering to Seal-A-Smile" to raise awareness of the successful work of SAS projects.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance is being provided to 21 statewide grantees primarily in cooperation with the Children's Health Alliance.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

We are publishing the results of the 2008 3rd grade oral health survey and completing our second statewide Head Start oral health assessment.

c. Plan for the Coming Year

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Heath Care Services--Children

We anticipate funding at least 20 community and school-based dental sealant programs. We also anticipate receiving additional funding from HRSA that would allow for significant expansion of the SAS program.

A Dental Sealant Coordinator will be hired by the Division of Public Health Oral Health Program.

The Oral Health Program will be working with Children's Health Alliance on the goals and objectives of the HRSA funded "Wisconsin Community Based System of Oral Health with CYSHCN", specifically targeting school based opportunities to reach children.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

The Program will continue to support MCH-funded sealant program activities and will advocate to agencies for their participation.

The Program will also continue to contract with Children's Health Alliance to administer the Seal-A-Smile program and provide training and guidance to new staff.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance will be provided to at least 20 statewide project grantees in cooperation with the Children's Health Alliance.

The State Chief Dental Officer and Public Health Dental Hygienist will continue to play an active

role in the Wisconsin Oral Health Coalition.

The Program will be holding a statewide Health Start Oral Health Needs Forum that will engage a diverse number of partners.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

The Healthy Teeth for a Healthy Head Start oral health assessment of Head Start students will be completed and data disseminated.

The 2008 Make Your Smile Count 3rd grade oral health assessment will be used to provide a framework for the WI Oral Health Coalition for program and policy development and community advocacy.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.2	3.2	3.1	2.8	2.8
Annual Indicator	2.5	2.8	1.8	2.5	2.5
Numerator	27	30	19	27	27
Denominator	1073202	1062378	1078955	1086602	1086602
Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 04/08/2009.

Notes - 2006
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 04/08/2008.

a. Last Year's Accomplishments

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2008, 37 LHDs conducted checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This was the most commonly selected objective, with $334,184 in Title V dollars going toward this effort in Wisconsin.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continued in 2007. Staff from DPH provided technical assistance to LHDs for implementation and sustainability of CPS programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continued to utilize partnerships with DOT, law enforcement agencies, local hospitals, EMS, SAFE KIDS and local businesses to support their efforts to provide education and services pertaining to child passenger safety. Money was also available from DOT for staff training and education and for purchasing car seats for low income families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Car Seat Safety Education and Fitting/Inspections		X		
2. Community Education and Outreach			X	
3. Enhancement and Expansion of Partnerships				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2009, 37 LHDs are conducting checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This is the most commonly selected objective, with $358,594 in Title V dollars going toward this effort in Wisconsin. We are continuting to evaluate this objective to assure that it meets the needs of both LHDs and the MCH program.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continues in 2009. The number of LHDs who selected this objective remained the same between 2008 and 2009. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, fire departments and local business to support this activity. We have enhanced our technical assistance to LHDs by providing CEUs to technicians free of charge through the MCH program.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT, law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

c. Plan for the Coming Year

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

It is anticipated that LHDs and others will continue to provide child passenger and car seat safety outreach, seats, training, and education to families with young children. We hope to increase the number of LHDs that select child passenger safety template objectives through the performance-based contracting system.

2. Community Education and Outreach--Population-Based Services--Infants and children

We will continue to collaborate with DOT, which has been able to provide funding for safety seats for low income families in the past, and other state and local agencies to promote and provide outreach activities and public education. We will support LHDs in forming partnerships with local entities, and provide technical assistance in development of local programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

As opportunities are identified, new partnerships will be developed and/or current ones strengthened to accomplish the work of the new projects and initiatives.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			40	25	26
Annual Indicator		25.0	26.0	26.6	27.1
Numerator		2810	3309	3622	3784
Denominator		11238	12726	13616	13963
Data Source					CDC PedNSS 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	29	30	32	33

Notes - 2008

Source: 2008 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: According to PedNSS 2006, 77% Hispanic infants were ever breastfed compared to 63.9% white infants, 47.2% African American, 62.1% American Indian/Alaskan Native, 43.8% Asian/Pacific Islander and 59.4% multiple races; for breastfed at least 6 months, 35.1% Hispanic infants were breastfed, compared to 20.9% white infants, 10.3% African American, 18.9% American Indian/Alaskan Native, 14.4% Asian/Pacific Islander and 12.6% multiple races.
Data issue: The data for 2005 cannot be amended in the TVIS; the data entered for 2005 are incorrect and should be 2,519/10,409 = 24.2%. Source: 2005 Pediatric Nutrition Surveillance System report (PedNSS); received from CDC in mid-January 07.
The subsequent years' objectives were revised to reflect 2004 and 2005 data that indicated about 25% of mothers breastfed their infants at 6 months of age. The HP 2010 objective is 50%; however, given current data and program knowledge, we feel that our objectives do not reflect current breastfeeding practices and have revised them downward.

a. Last Year's Accomplishments
1. Breastfeeding Education, Promotion and Support--Direct Services--Pregnant and breastfeeding women

In 2008, 16 LPHDs worked on the 10 Steps to Breastfeeding Friendly Health Departments multi-year template objective. One LPHD achieved the designation of "Breastfeeding Friendly" status and was recognized as the first Breastfeeding Friendly Health Department in Wisconsin. This process included completion of a self-assessment tool, all 10 Steps and accompanying required activities.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The State WIC Breastfeeding Coordinator managed the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In CY 2008, the WIC Program trained 18 new breastfeeding peer counselors who provided prenatal breastfeeding counseling and postpartum support in 32 local WIC projects statewide. Breastfeeding peer counseling improved the duration rates of breastfeeding as evidenced by the WIC Breastfeeding Incidence and Duration Report, i.e., the BFPCP 6 month duration rate was 26.2 % compared to the State average of 24.2 %. The WIC Breast Pump Program provided breast pumps to WIC mothers not eligible for Medical Assistance. A WIC Breastfeeding Warm Line was developed for use outside business hours in the area of the state with the highest infant mortality rates.

The Title V funded agencies continued to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator co-chaired the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). A key obesity prevention focus area of WI PAN is the promotion and support of breastfeeding. The Breastfeeding Committee developed the "10 Steps to Breastfeeding Friendly Childcare Centers" resource kit. This resource will be used by breastfeeding coalitions and public health professionals to train childcare staff.

4.Collaboration and Partnerships: Local Breastfeeding Coalitions--Infrastructure Building--

Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN planned to develop and distribute a survey for the local breastfeeding coalitions to assess specific breastfeeding coalition needs, best means to address needs and optimal approaches for networking.

The WIC Breastfeeding Coordinator presided as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding Education, Promotion and Support	X			
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Partnership for Activity & Nutrition			X	
4. Collaboration and Partnerships - Local Breastfeeding Coalitions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Breastfeeding Education, Promotion and Support--Direct Health Services--Pregnant and breastfeeding women

In 2009, 21 LPHDs will be completing the 10 Steps to Breastfeeding Friendly Health Departments objective. Self-assessment tools and LPHD reports that describe strategies and activities implemented will be reviewed. LPHDs that have completed required activities of all 10 Steps will be awarded the "Breastfeeding Friendly" status.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The WIC Program trained 15 new breastfeeding peer counselors who provide breastfeeding counseling and support in 37 local WIC projects statewide. Breastfeeding peer counseling improved the duration rates of breastfeeding as evidenced by the most recent run of the Breastfeeding Incidence and Duration Report, i.e., the BFPCP 6 month duration rate was 27.3% compared to the State average of 25.8%.

3. WI PAN--Population-Based Services--

The Breastfeeding Committee of WI PAN will promote and distribute the "10 Steps to Breastfeeding Friendly Childcare Centers" module to local breastfeeding coalitions, public health professionals, and other lactation professionals to train childcare staff and early childhood education professionals.

4.Collaboration and Partnerships: Local Breastfeeding Coalitions--Infrastructure Building--

The Breastfeeding Committee of WI PAN will survey local breastfeeding coalitions.

c. Plan for the Coming Year

1. Breastfeeding Education, Promotion and Support--Direct Health Care Services--Pregnant and breastfeeding women

In CY 2009, 21 LPHDs will be completing the 10 Steps to Breastfeeding Friendly Health Departments objective. Self-assessment tools and LPHD reports that describe strategies and activities implemented by the health department that are required in the 10 Steps will be reviewed. LPHDs that have completed required activities of all 10 Steps will be awarded the "Breastfeeding Friendly" status.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The State WIC Breastfeeding Coordinator will continue to manage the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In addition to the 3 day Loving Support Training for the new peer counselors, continuing education programs will be provided for experienced peer counselors.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator will continue to co-chair the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). The Breastfeeding Committee will promote and distribute the "How to Support a Breastfeeding Mother -- A Guide for the Childcare Center" to breastfeeding coalitions and public health professionals to train childcare staff.

4. Collaboration and Partnerships: Local Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

In 2010, the Breastfeeding Committee of WI PAN will evaluate a survey for the local breastfeeding coalitions. Plans to stregthen the local coalitions will be developed based on survey results identifying breastfeeding coalition needs, best means to address needs and optimal approaches for networking.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	94	95	95	95	97.5
Annual Indicator	94.5	95.6	94.5	97.2	96.5
Numerator	65528	65780	66675	69364	68382
Denominator	69308	68785	70519	71389	70862
Data Source					WI WETRAC 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	97.5	97.8	97.8	98	98

Notes - 2008
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Records for infants who show PASS/PASS results are archived; records for infants who REFER in one or both ears are queued for follow-up by the birth hospital. Reports started being generated directly from the WE-TRAC system for 2007 data. This method has allowed issues that occurred in the past, such as duplicate records that were difficult to identify as duplicates and babies with delayed screening or not screened for valid reasons but accounted for, to be corrected. Since the removal of the separable metabolic screening card, hospitals are faxing WE-TRAC users delayed hearing screening results to the WSLH. This is making our user much more responsible for updating their records accurately and in a timely fashion.

Notes - 2007
Hearing screening data are reported on the newborn blood-spot card that is sent from the birth hospital to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Unlike the data reported in previous years from WSLH records, the 2007 data are generated directly from the WE-TRAC system. This method has helped resolve accuracy issues involving duplicate records and delayed records that occurred in the past. The data adhere to the CDC reporting standards for EHDI statistics; i.e., the screened number excludes newborns who were missed in one or both ears, refused screening, or died before screening was possible.

Notes - 2006
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are delivered as a space-delimited file at least once a month, converted to a SAS dataset, and used to compile monthly reports on hearing screening in Wisconsin. The hearing screening records are also sent directly to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) System.
Data issues: Hearing screening results are occasionally separated from the blood card, delaying accurate reporting. Alternatively, sometimes the blood screening is repeated, but not the hearing screening, therefore, there may be duplicate (inaccurate) reporting. In 2006 functionality was added to WE-TRAC to allow administrators to remove duplicate records from the WE-TRAC data set. Currently, we are developing reports that will allow us to take data from WE-TRAC rather than from the blood card file. This will allow for more accurate data, and will also allow us to include data on delayed inpatient screenings done for special care infants, and report on other "accounted for" babies, or babies that have a valid reason for not being screened. With these new reports and the rapid increase of hospitals reporting using WE-TRAC, we anticipate being able to use WE-TRAC data for future reporting.

a. Last Year's Accomplishments
1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

WSB disseminated the EHDI Video to community partners and collaborated with the WESP DHH Program to disseminate the newly created "just in time" packet for early intervention providers for newly diagnosed children. WSB sent 87 number of "just in time" packets to primary care providers of newly diagnosed infants. WSB marketed existing materials and revised the Babies and Hearing Loss Notebook for Families. Outreach to the Latino population included the promotion of the Public Service Announcement developed by the CDC Committee on Diversity. La Movida radio station played the message at no charge twice daily during prime drive times and added a voice addition to the PSA that included WI contact numbers. A family that was identified

as lost to follow-up heard the message, contacted the toll-free number, and was successfully re-entered into the EHDI system by eliminating the insurance barrier to audiologic care.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB continued to coordinate follow-up with the WSLH and worked to improve data quality. We have worked to eliminate delayed submission of hearing results on the blood card via a new feature in WE-TRAC and investigated the collection of risk factors for late onset hearing loss.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The 8th Annual Statewide Parent Conference and professional pre-conference was held with a major focus on parent professional teamwork. 178 professionals attended the pre-conference and 89 families attended.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

We have investigated linking WE-TRAC to the new web-based Birth-3 data system. We have also developed a systematic way of collecting date of Birth-3 enrollment. From this process we determined that 59 out of 91 eligible children with hearing loss received early intervention services and 32 of the 59 enrolled children had their initial IFSP developed prior to the target timeline of 6 months of age.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

This workgroup underwent a conversion to focus on quality improvement efforts and is now called the EHDI Quality Improvement Consortium.

6. Reduce Lost to Follow-up--Infrastructure Building--CYSHCN

Guide By Your Side Follow-through Program and WE-TRAC reports continue to be developed and implemented. WSB initiated an18 month EHDI Learning Collaborative. In September 2008 a team of experts (parent leader, primary care (Medical Home), birth hospital, ENT, audiology, early intervention, genetics), evaluated key change concepts and measurement strategies and adapted them to meet Wisconsin needs. They also assisted in developing the structure, timeline, and make up of the Wisconsin replication. The WI LC was designed to include: a pre-session, regional team meetings, statewide learning sessions, and action periods. WSB recruited community teams, comprised of primary care providers, birth hospital staff, audiologists, early interventionists, and parents representing 15 counties. There are ENTs and genetic counselors on teams providing regional representation. Within each of the community teams, a data manager and key contact have been designated along with four regional parent guides to provide expertise to teams and support the local parents that are participating. An introductory pre-session meeting was held in two locations to support the attendance of the greatest number of teams. The pre-session meeting provided an overview of the LC, explained quality improvement methodology and measurement strategies, introduced the expectations for pre-work and on-going data collection, and supported time for teams to network and plan for the accomplishment of the pre-work. WSB with the UW-Madison Waisman Center developed an interactive web-based common space where all of the meeting materials and minutes are available. Community teams are able to upload materials and there are discussion boards. This site serves as a bank of materials and knowledge that can be shared by all participants of the LC.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Outreach/Public Education		X		
2. WSB/Congenital Disorders Program			X	
3. Support Services for Parents	X			
4. Birth-3 Technical Assistance Network				X
5. EHDI Workgroup				X
6. Reduce Lost to Follow-up				X
7.				
8.				
9.				
10.				

b. Current Activities

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

WSB continues to evaluate and improve just in time packets.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB coordinates follow-up with the WSLH and works to improve data quality. Delayed or missing hearing screening results will be submitted through WE-TRAC via faxes from birth hospitals. WSLH began collecting risk factors for late onset hearing loss on newborn screening cards. We are developing a notification letter for physicians who care for children with risk factors of hearing loss. We are investigating the input of hearing screening results for clients without blood screen.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The 8th Annual Statewide Parent Conference is being planned.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified as deaf or hard of hearing will be electronically referred to Birth-3 via WE-TRAC. Reports will identify the numbers of children with hearing loss referred to early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI QI Consortium is underway.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

Learning sessions focusing on reduction of lost to follow-up are being conducted. A toolkit is being designed as a resource to Learning Collaborative participants.

c. Plan for the Coming Year

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

WSB will continue to collaborate with the WESP DHH Program to evaluate and improve "just in time" packets for early intervention providers when we receive notification of a newly diagnosed child.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB will continue to coordinate follow-up with the WSLH and work to improve data quality. Delayed or missing hearing screening results will be submitted through WE-TRAC via faxes from the birth hospitals. WSLH will continue to collect risk factors for late onset hearing loss on the newborn screening card. We will be notifying physicians to follow up with a hearing screening for those at risk infants per the recommendations by the Joint Commission on Infant Hearing.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

An Annual Statewide Parent Conference and professional pre-conference will occur, with a major focus on parent and professional teamwork.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified as deaf or hard of hearing will be connected to Birth-3 via WE-TRAC and reports will continue to be generated to determine the current numbers of children with hearing loss referred to early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI Quality Improvement Consortium will continue.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

The learning collaborative will be completed along with the creation of the WI EHDI Quality Improvement Toolkit for Providers. WSB along with EHDI QI Consortium members will continue to spread improvement strategies utilizing the toolkit. The Guide By Your Side Follow-through Program and WE-TRAC system will continue to be developed, enhanced, and implemented.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.9	2	2	2.8	2.7
Annual Indicator	2.2	2.9	3.8	2.4	2.4
Numerator	28000	38100	48000	31000	31000
Denominator	1300000	1300000	1273000	1293000	1293000
Data Source					WI DHS BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.6	2.5	2.5	2.5	2.4

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2007. Madison, Wisconsin: 2009.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1)Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2006. Madison, Wisconsin: 2008.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1)Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

a. Last Year's Accomplishments
1. Medicaid outreach overview--Enabling Services--Children, including CYSHCN

Title V, MCH program staff monitored enrollment trends in Wisconsin Medicaid and in BadgerCare Plus, the Wisconsin CHIP Program. Since implementation of BadgerCare Plus in February 2008 (WI Medicaid and SCHIP programs) with coverage available to all children in the State, the number of children covered has increased 63,545. Of these children, 3937 are eligible for the benchmark plan at family incomes above 250% FPL. The MCH program maintained the connection to outreach program activities and children at risk served by the CYSHCN Regional Centers in five locations throughout Wisconsin.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Legislation to implement BadgerCare Plus was passed in September 2007 in the SFY 07-09 budget and the program began enrolling families on February 1, 2008. Since implementation of BadgerCare Plus that combined WI Medicaid and SCHIP programs to cover children in the State, the number of children covered has increased 63,545. Of these children, 3937 are eligible for the benchmark plan at family incomes above 250% FPL. Community partners outreached to families about the program's benefits and provided direct, confidential application assistance. In some cases, children were able to receive immediate, express enrollment in BadgerCare Plus through these community partners.

3. "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The "Covering Kids" Program in Wisconsin (CKF-WI) is housed at the UW-Madison School of Human Ecology, working in partnership with UW-Extension and other partners throughout the state. It is a coalition of more than 65 organizations committed to reducing the number of uninsured children and families. CKF has shifted its focus to the CHILD Project, which seeks to develop capacity within Wisconsin's public schools to provide needed information and assistance for children and their families who lack health insurance and may be eligible for coverage under BadgerCare Plus, Wisconsin's public health insurance program. CKF-WI is making sure those who are eligible for BadgerCare Plus know about and can easily enroll in the programs for which they qualify.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Outreach Overview		X		
2. Governor's BadgerCare Plus Initiative		X		
3. "Covering Kids" Program		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Title V MCH/CYSHCN Program continues to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Plus Program that provides health insurance for all children in the state. The MCH program will have an opportunity to assist implemenation of the BadgerCare Plus enrollment and retention efforts funded by a recent grant from Robert Wood Johnson Foundation.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program continues to provide support for state and local coalitions, funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

c. Plan for the Coming Year

1. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Program that is to provide an opportunity for health insurance for all children in the state and improve access to health care coverage.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program will continue to provide support for state and local coalitions that are funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			12.1	29	28
Annual Indicator		13.3	29.3	29.2	29.9
Numerator		6893	15137	15078	16707
Denominator		51825	51667	51636	55875
Data Source					CDC PedNSS 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29.9	29.8	29.7	29.6	29.5

Notes - 2008
Source: 2008 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: 2006 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. The subsequent years's objectives were revised to reflect the correct data for 2005 and program knowledge about this population.

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting (PBC), 14 LHDs worked to create environments that promote breastfeeding, healthy eating, physical activity, and a healthy weight. These activities are linked to Healthiest Wisconsin 2010, the Wisconsin Nutrition and Physical Activity State Plan and local community health improvement plans. Many provided educational, policy and environmental change opportunities in community, worksite, school, healthcare, childcare and afterschool settings. Two LHDs worked with childcare to implement "Color Me Healthy" curriculum reaching over 270 pre-school children. A LHD focused on implementing a worksite wellness program in 2 school districts reaching 215 employees. Several LHDs provided education on healthy eating and being physically active through events, at the county fair, and the media.

2. Community Capaigns--Popultion-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs promoted nutrition and physical activity in their communities through a variety of campaigns. This includes a Fun/Run Walk with 113 participants with 160#'s of food donated to the food pantry; a Turn Off TV Week challenge with 519 participants; a Walk to School Challenge with 9,337 participants from 10 schools in the community; a community

"Saturday Morning Walk" that inceased access to public facilities for physical activity; a multi-worksite wellness challenge; and a walk/bike to work challenge with 438 miles walked, 288 miles biked and 58,276 calories burned.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs improved the nutrition and physical activity environment in their communities. Strategies implemented included community/coalition capacity building and planning, walkability/bikeability surveys, community health improvement plan development, worksite assessments, the Governor's School Health Award criteria, breastfeeding support at work, sustainability planning, outreach to key stakeholders in the community, and a Healthy Communities Award to recognize youth.

4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing and managing overweight and obesity. There were ~40 local coalitions focused on obesity prevention efforts in 2008. Key partnerships that were developed/maintained by the coalitions/LHDs included: recruiting and retaining coalition members, schools, worksites, childcare, farmers' markets, UW-Extension, Master Gardeners and Food Preservers, WIC, YMCA, after-school programs, media, minority organizations and parent groups. In many examples the work funded by MCH and through the partnerships has been able to leverage additional grant funds, in-kind services and support.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plan				X
4. Nutrition and Physical Activity Coalitions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting, 10 LHDs are creating environments that promote breastfeeding, healthy eating, physical activity and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs are promoting nutrition and physical activity in their community. These include a Fun Walk/Run, Safe Routes to School, Turn off TV Week, and Healthy Community Award.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs are improving the nutrition and physical activity environment and building the infrastructure. Strategies include: walkability/bikeability surveys, childcare environment assessments, Safe Routes to School, school wellness, assessment of breastfeeding services, worksite wellness, farmers markets, Got Dirt? Garden Initiative, and childcare curriculum.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 38 local coalitions focused on nutrition, physical activity & obesity prevention.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting system, LHDs will be encouraged to choose a template objective that provides focused effort related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreased consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases. Both plans will be updated.

2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the Wisconsin Nutrition and Physical Activity State Plan. Campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition, Physical Activity and Obesity Program will disseminate resources to LHDs, coalitions, and community-based organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will continue to promote the use of the State Plan as a "blueprint" for activities to prevent and manage overweight among children and their families.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~38 local coalitions who will focus on preventing overweight, improving nutrition and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, safe neighborhoods, access to healthy food as well as food security and hunger. An annual survey will be conducted to capture current capacity to implement interventions, identify training and resource needs and highlight

successes.

Key partners include: the WIC Program, DPI programs, the Child and Adult Care Feeding Program, Dept. of Transportation, Dept. of Agriculture, UW-Extension, Minority Health Program, LHDs, and community coalitions.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			14.5	14	13.5
Annual Indicator		14.0	14.9	14.9	14.9
Numerator		9812	10715	10843	10843
Denominator		70012	72114	72560	72560
Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13.5	13.5	13	13	13

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2009.

Notes - 2007
Data issue: 2007 data will not be available from the Bureau of Health Information and Policy until 2009. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2008 or early 2009.

Notes - 2006
Source: The data for 2005 are wrong; they should be: 9,503/70,719 = 13.4%; the 2005 data were entered as provisional data for the 2007 application. There were 70,934 births in Wisconsin in 2005. Birth certificate data indicate that 61,216 reported they did not smoke during pregnancy; 9,503 reported smoking, and there were 215 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2007.
Data issues: The data for this indicator are not available in Wisconsin. Therefore, we are using

data for SPM #7, the percent of women who use tobacco during pregancy. 2006 data will not be available from the Bureau of Health Information and Policy until 2008. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system projected to be in place by 2009. Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until 2008-2009.

a. Last Year's Accomplishments
Relates to Priority Need #7 - Smoking and Tobacco Use. In 2007, birth certificate data indicated 14.9% of Wisconsin women smoked during pregnancy, the same rate as 2006.

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers and infants

The Title V Program funded 36 LHDs totaling 44 objectives addressing a variety of perinatal-related issues.

As reported for 2008 in SPHERE, of those women who received a prenatal assessment utilizing both Title V funds and Medicaid PNCC 49% reported smoking before pregnancy, 33% reported smoking during pregnancy, and 60% reported decreasing smoking during pregnancy. Other SPHERE data show of the women whose smoking changed during pregnancy and were followed, 76% reported maintenance of non-smoking status and 44% reported exposure to secondhand smoke in their household.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). In 2008 1,502 women enrolled in the First Breath Program. Between 2006 and 2008 there was a 48% increase in African American participants in the First Breath Program; a result of concentrated expansion and continued support and technical assistance to sites in Southeastern Wisconsin. A prenatal quit rate of 34% exceeded the program goal of 25%. 79.7% of the program's participants were Medicaid recipients in 2008.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers and infants

The focus of this group is on tobacco use and cessation among women of reproductive age. Due to lack of resources to support this effort, this activity will be addressed under the First Breath Program. The results of the clinician survey will determine priority areas for provider education.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

Through the Medicaid PNCC program and the MCH-funded perinatal care coordination program, pregnant women identified as high risk for adverse pregnancy outcomes receive strength based individual care in the prenatal period and postpartum. One of the individual foci is tobacco use and cessation. Individuals are referred to the First Breath Program. In SFY 2008, 949 women reported making a change in tobacco use during the prenatal and postpartum period and 76% of those women served by these programs reported not smoking in the postpartum period.

5. Preconception Services--Enabling Services--Pregnant women, mothers and infants

Infant Death Center of Wisconsin (IDC) facilitated a safe sleep/smoking cessation workgroup for a coalition of representatives from Milwaukee hospitals. The WAPC Preconception Committee surveyed healthcare providers about preconception practices and knowledge including smoking cessation and the preconception tool kit for use in clinics was disseminated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Women and Tobacco Team (WATT)				
4. Prenatal Care Coordination (PNCC)		X		
5. Preconception Service		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Serivces--Pregnant women, mothers and infants

The Title V program funded 55 LHDs totaling 83 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

For CY 2009, 101 First Breath sites are participating in the program and 373 women have been enrolled. First Breath participants continue to be predominately of non-Hispanic white race, low income and low education level.

3. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

Education sessions for the Great Beginnings Start Before Birth curriculum are being offer to all PNCC providers regionally.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The IDC of Wisconsin continues working with the safe sleep/smoking cessation workgroup and the community on education for creating smoke free environments. The WAPC Preconception Committee continues to plan for educating clinical providers on preconception health with a smoking cessation focus.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Serivces--Pregnant women, mothers and infants

Due to the complex nature of smoking during pregnancy, this topic will continue to be a priority for the Title V Program. The provision of Title V funds and appropriate resources will be determined as a result of the Needs Assessment.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath Program. This partnership will focus on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to

cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, continue expansion efforts in Southeastern Wisconsin and increase enrollment at First Breath Tribal Clinics.

3. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

The Medicaid PNCC and the MCH-funded perinatal care coordination programs will continue to support the comprehensive strength based services to women during the prenatal and postpartum period. The Great Beginnings Start before Birth curriculum will be offered statewide 1-2 times as needed. Through the regional PNCC provider groups data collected on key outcomes will be shared amongst LHDs with discussion on plans for improvement. Healthy Baby Action Teams will work to identify and possibly pilot innovative uses of technology to educate and send messages to pregnant women.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

Through local coalitions in 4 high risk communities and Native American tribes, the IDC will continue to provide preconception/interconception information that focuses on women's health, including smoking cessation. IDC will collaborate with the ABC's for Health Families project in Milwuakee to develop and disseminate social marketing messages on tobacco use during pregnancy and second hand smoke for infants. The WAPC preconception committee will continue to develop an educational tool for clinical providers on preconception health including smoking cessation. Additionally they are focusing on preconception materials for men.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	9	9.2	9	8.7
Annual Indicator	9.5	11.0	8.4	7.7	7.7
Numerator	39	45	34	31	31
Denominator	409811	409101	404777	402172	402172
Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.6	8.5	8.5	8.5	8.3

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2008.

a. Last Year's Accomplishments
1. Anticipatory Guidance, Risk Assessment and Referrals--Direct Health Care Services--Adolescents

The Title V MCH/CYSHCN Program continued to work with community and professional groups to promote prevention, assessments, referrals and intervention.

2. Training and Presentations to Raise Awareness and Reduce Stigma--Population-Based Services--Adolescents

Suicide Prevention Initiative partners and others continued to provide training, presentations, workshops, and displays at conferences and events. The SPI became more involved through the Garrett Lee Smith grant to fund youth suicide prevention efforts. Members of the SPI provided technical assistance to local health departments utilizing MCH fundsfor suicide prevention activities as well.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

Implementation of "Healthiest Wisconsin 2010" is ongoing along with the statewide suicide prevention strategy. Growth of the SPI continues to strengthen the infrastructure of suicide prevention in the state.

4. Data--Infrastructure Building Services--Adolescents

The Wisconsin Violent Death Reporting System (WVDRS) continues to collect, analyze and disseminate data on suicides. These data include information for the 15-19 year old population. Injury and Violence Prevention Program (IVPP) staff, along with partners at the Injury Research Center (IRC) at the Medical College of Wisconsin completed the Burden of Suicide Report. The report was disemminated to all health departments and many community partners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Anticipatory Guidance, Risk Assessment and Referrals	X			
2. Training and Presentations to Raise Awareness and Reduce Stigma			X	
3. Suicide Prevention Initiative (SPI)				X
4. Data				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

Work with community and professional groups to promote prevention, assessments, referrals and intervention is continuing. A template objective for the performance-based contracting system has been offered with two of WI largest health departments choosing it for 2009.

2. Training and Presentations--Population-Based Services--Adolescents

Members of SPI and other community partners met to plan activities for improving WI infrastructure around suicide prevention. The MCH and Injury and Violence Prevention Program will be leaders in the development and implementation activities to come. Training will also occur on the data and use of the Burden of Suicide Report.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

SPI will continue to work with the Garrett Lee Smith grantees to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already have programs and activities in place.

4. Data--Infrastructure Building Services--Adolescents

WVDRS will continue to collect, analyze and disseminate data on suicides, including specific information for the 15-19 year old population by state, county, sex , incident location, and circumstances.

c. Plan for the Coming Year

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

Work with community and professional groups to promote prevention, assessments, referrals and intervention will continue. The template objective for the performance-based contracting system will continue to be offered.

2. Training and Presentations--Population-Based Services--Adolescents

Training will also continue on the data and use of the Burden of Suicide Report.SPI members will continue to support and present training and presentations to a variety of audiences.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

SPI will continue to work with the Garrett Lee Smith grantees, local health departments and other community partners to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already have programs and activities in place. They will also be focusing on carrying out the improvments to enhance Wisconsin's overall infrastructure.

4. Data--Infrastructure Building Services--Adolescents

WVDRS will continue to collect, analyze and disseminate data on suicides, including specific information for the 15-19 year old population by state, county, sex, incident location, and circumstances.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	81	81.5	82	82.5
Annual Indicator	77.4	80.6	74.8	75.8	75.8
Numerator	655	712	667	623	623
Denominator	846	883	892	822	822
Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	76	76	76.5	76.5	77

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 78.7%, 72.9%.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 77.6%, 72.0%.

a. Last Year's Accomplishments
Impact on National Outcome Measures: NPM #17 relates to National Outcome Measures #1 Infant mortality rate and #3 Neonatal mortality rate. Hospitals in Wisconsin self designate level of perinatal care. Wisconsin does not have regulatory function over the designations.

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

The Wisconsin Association for Perinatal Care continued to facilitate activities to support the use of levels of perinatal care adopted from the American Academy of Pediatrics definition of levels of neonatal care: Level I provides well newborn care for infants and stabilizing care for infatns of 35-37 weeks gestation and beyond; Level IIA provides care for preterm or ill infants requiring stabilization efforts and are either expected to recover rapidly or are awaiting transfer to another facility; Level IIB provides care at IIA level plus mechanical ventilation for brief durations or

continuous positive airway pressure; Level IIIA provides comprehensive care for infants born >28 weeks and weighing >1,000 gms, able to provide life suppor and mechanical ventilation in addition to minor surgical procedures; Level IIIB provides comprehensive care for the extremely low birth weight infant (28 weeks, 1,000 gms) with advanced respiratory support, full range of pediatric subspecialists, advanced imaging and surgical abilities; Level IIIC provides comprehensive care for premature infants at the IIIB level in addition to being able to provide ECMO and complex surgeries. WAPC has provided education on the self assessment tool to birth hosptials and the listing of hospitals that have submitted the self-assessments are located on their website, www.perinatalweb.org.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WAPC Efforts on Regionalization of Perinatal Care				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

The Wisconsin Association for Perinatal Care is continuing to support the use of the self-assessment tool and materials about the levels of perinatal care. The results of the initial completed assessments will be posted on the WAPC website, www.perinatalweb.org.

c. Plan for the Coming Year

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC will obtain information about the levels of care birth hospitals provide that mirror the levels proposed by AAP. They will then make this information available on the WAPC website. WAPC will continue to support the use of PeriData.Net, a web-based perinatal database, for quality improvement in birth hospitals. They will work with birth hospitals on the collection and sharing of data about birth processes and outcomes.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	85	85.5	86	86.5	87
Annual Indicator	85.1	85.0	83.8	82.8	82.8
Numerator	59666	60309	60610	60257	60257
Denominator	70131	70934	72301	72757	72756

Data Source					WI DHS/BHIP 2009.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	84	84	84.5	85	85

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/16/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/29/2008.

a. Last Year's Accomplishments
Impact on National Outcome Measures: NPM #18 relates to National Outcome Measures #1 Infant mortality rate, #2 Disparity betweeen Black and White IMR, #3 Neonatal mortality rate, and #5 Perinatal mortality rate. The overall proportion of women who receive prenatal care in the first trimester was 83% in 2007, compared to 84% in 1997. The proportion with first trimester care increased for mothers aged less than 15, 18-19, 20-24, and 30-34; in all race/ethnicity groups except whites.

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V program funded 1,196 women served through objectives addressing prenatal care. As reported in SHPERE and MCH end of year reports, 59.7% of women initiated prenatal care in the first trimester.

2. Prenatal Care Coordination(PNCC)--Enabling Services--Pregnant women, mothers, infants

Medicaid PNCC services assists high risk pregnant women to receive early and continuous prenatal care. The Great Beginnings Start Before Birth curriculum was provided to enhance PNCC services to local health departments and other agencies in 1 public health region. Training sessions for PNCC were provided for local health departments and other agencies through regional PNCC provider meetings. The Women's Health Now and Beyond Pregnancy project provided services that included women having emergency contraception and dual protection, with a plan for primary birth control on hand prior to delivery; along with promotion of the continued use of multivitamins with folic acid. Empowering Families of Milwaukee completed 3 years of providing comprehensive home visiting services. 98% of the women enrolled during early pregnancy.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women,

mothers, infants

Title V MCH/CYSCHN staff have continued to serve on advisory committees for the Healthy Start projects. The Black Health Coalition's Milwaukee Healthy Beginnings Project (MHBP) has continued to support the FIMR project and local Service Provider Meetings. The CEO and Project Director of the MHBP actively participate in department facilitated workgroups to eliminate racial and ethnic disparities in birth outcomes. The Honoring Our Children Project with Great Lakes Inter-Tribal Council reports 80% (110/160) of prenatal women received first trimester services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. Prenatal Care Coordination (PNCC)		X		
3. Federal Healthy Start Projects in Wisconsin			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women,mothers, infants

The Title V MCH/CYSCHN Program is funding 34 objectives at local health departments to address prenatal issues.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Trainings on PNCC have been scheduled for 2 public health regions with a focus on data collection and outreach. Trimester of entry into prenatal care is a key data item that is measured. The Women's Health Now and Beyond Pregnancy pilot project continues to service women during the prenatal period. Great Beginnings Start Before Birth curriculum is being offered in 4 public health regions to PNCC providers at local public health departments and other agencies. Empowering Families of Milwaukee contractual responsibilities transferred to the Department of Children and Families. An MCH conference with a focus on the life course perspective of health and its relationship to birth outcomes is being offered statewide.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSCHN staff serve on advisory committees for the Healthy Start Projects. Great Beginnings Start Before Birth curriculum training is being offered to tribal sites. PNCC training was offered individually to 1 tribal site with a second one scheduled as they implement community health workers into their program. For information on FIMR see HSCI #5B.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V MCH/CYSHCN Program will continue to fund individual perinatal care coordination

services at the local level with a focus on interconception care for high risk women.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women,mothers,infants

PNCC services will continue to support early entry into prenatal care for Medicaid-eligible pregnant women who are at high risk for a poor birth outcome. Statewide training session for Great Beginnings Start Before Birth curriculum will be provided regionally. MCH Data Sheets will be promoted through PNCC provider group meetings to support monitoring of outcomes of prenatal services at the local level, including trimester when prenatal care was initiated. The Women's Health Now and Beyond Pregnancy pilot project will evaluate data outcomes and plan for including these services in future contract objectives. The Medicaid PNCC guidelines will be revised with a greater focus on outreach, communication with partners, and data collection of key outcome indicators. Training will be offered through regional PNCC provider groups on the new guidelines. Both the DCF and DHS have a signed MOU and will collaboratively support the home visitation programs.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSCHN staff will continue to serve on advisory committees for the Healthy Start projects. PNCC trainings will be offered to tribal sites. The Milwaukee Healthy Beginnings Project will be implementing PNCC services.

D. State Performance Measures

State Performance Measure 1: *Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			24.4	24	26
Annual Indicator	17.3	22.7	22.2	21.1	20.3
Numerator	55515	64059	62935	59799	57459
Denominator	320422	282070	282970	282970	282970
Data Source					WI DHS/DHCAA 2009.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	22	23	24	25

Notes - 2008
The federal Deficit Reduction Act (DRA) implemented several provisions that resulted in decreased enorllment in all Medicaid program, including the Family Planning Waiver; we have revised objectives accordingly.

Notes - 2007
Source: 2007 enrollment data from Wisconsin Department of Health and Family Services, Division of Health Care Financing, Medicaid program data.
Data issue: These data represent a point in time and the number of women enrolled in the FPW as of 12/31/2007; therefore, the data are subject to fluctuations and there was a slight decrease in 2007 compared to 2006.

Notes - 2006
Source: 2006 enrollment data from Wisconsin Department of Health and Family Services, Division of Health Care Financing, Medicaid program data.
Data issue: These data represent a point in time and how many women were enrolled in the FPW as of 12/31/2006; therefore the data are subject to fluctuations and there was a slight decrease in 2006 compared to 2005.

a. Last Year's Accomplishments
1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

The federal Deficit Reduction Act (DRA) implemented several provisions that resulted in decreased enrollment in all Medicaid programs including the Family Planning Waiver. Public information and enrollment into the Waiver was a high priority in the Statewide Family Planning System. Outreach in Milwaukee was a priority to increase percentage of eligible women enrolled: 19% of eligible women were enrolled. Statewide, enrollment decreased but outreach activities prevented a further decrease in enrollment than otherwise would have occurred.

2. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

The MAPPP partnership of communtiy-based organizations focused on the development and adoption of evidence-based, focus-group tested messages. These included messages for Medicaid FPW outreach and services, as well as for contraceptive services and supplies including emergency contraception in advance of actual need and dual protection to prevent unintended pregnancy and reduce the risk of sexually transmitted disease. A youth advisory group was convened to develop effective messages and outreach materials.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach and Enrollment		X		
2. Milwaukee Adolescent Pregnancy Prevention Partnership		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

DRA continues to be a challenge. Public information and enrollment into the Waiver continues to be one of the highest priorities in the Statewide Family Planning System. Outreach in Milwaukee continues to be a priority to further increase percentage of eligible women enrolled above 19% of eligible women. Quality assurance/performance measurements have been established to monitor eligibility screening and enrollment in community-based family planning programs. A performance standard is to screen all patients for Waiver eligibility, and enroll patients on-site.

2. MAPPP--Enabling Services--Adolescents

The MAPPP partnership of community-based organizations focuses on public information based

on the evidence-based, focus-group tested messages that were developed. These include messages for Medicaid FPW outreach and services, as well as for contraceptive services and supplies including emergency contraception in advance of actual need and dual protection to prevent unintended pregnancy and reduce the risk of sexually transmitted disease. A youth advisory group continues to advise on channels of communication for the messages and outreach materials.

3. Program Performance Review--Infrastructure Building Services--Women of Reproductive Age

A program performance review will be conducted to identify policies and practices to improve outreach and enrollment, as well as other areas for quality improvement.

c. Plan for the Coming Year

1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

The federal Deficit Reduction Act (DRA) will continue to be a challenge to increase enrollment and reach a greater percentage of women in need of services. Public information and enrollment into the Waiver will continue to be one of the highest priorities in the Statewide Family Planning System. Outreach in Milwaukee will continue to be a priority to further increase percentage of eligible women enrolled above 19% of eligible women. Quality assurance/performance measurements will be expanded to monitor eligibility screening and enrollment in community-based family planning programs. The performance standard is to screen all patients for Waiver eligibility, and enroll patients on-site will be included in required chart audit plans.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The MAPPP partnership of community-based organizations will continue to focus on public information based on the evidence-based, focus-group tested messages that were developed. These included messages for Medicaid FPW outreach and services, as well as for contraceptive services and supplies including emergency contraception in advance of actual need and dual protection to prevent unintended pregnancy and reduce the risk of sexually transmitted disease. A youth advisory group will continue to advise on channels of communication for the messages and outreach materials.

3. Program Performance Review--Infrastructure Building Services--Women of Reproductive Age

Recommendations from the program performance review will be implemented: to promote policies and practices to improve outreach and enrollment, and to make family planning waiver enrollment more efficient and convenient. These will be incorporated into the next 5-year funding cycle for community-based family planning services.

State Performance Measure 2: *Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30.4	30.8	31
Annual Indicator	30.2	30.2	26.5	26.8	27.4
Numerator	72012	72012	106400	107997	116064
Denominator	238459	238459	401534	403190	423132
Data Source					WI DHS/DHCAA 2009.

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31	31	31.2	31.4	31.4

Notes - 2008
These data are for the State Fiscal Year.

Notes - 2007
Data issue: These data are for the State Fiscal Year. Data entered for 2007 were incorrect. They are: 107,997/402,190 = 26.8%.

Notes - 2006
Data issue: These data are for the State Fiscal Year. Data entered for the 2007, 2008, and 2009 applications were incorrect. They are:
2005: 106,594/391,928 = 27.2%; 2006: 106,400/401,534 = 26.5%.

a. Last Year's Accomplishments
1. Dental Sealant Program--Population-Based Services--Children, including CYSHCN

In 2008 the Wisconsin Seal-A-Smile (SAS) statewide school-based, school-linked dental sealant program provided funding to 21 community-based agencies totalling nearly $200,000. Data collected by each agency indicated that 6,254 children received sealants, 622 CYSHCN received screenings and 16,157 sealants were placed. During the 2008 school year the second statewide Make Your Smile Count oral health assessment of third grade children revealed that 50.8% of third grade children had evidence of sealant placement on at least one permanent molar.

2. Maternal and Early Childhood Oral Health--Population-Based Services--Pregnant women and mothers

In 2008, over 350 primary care providers and students were trained in Early Childhood Caries Prevention, including technical assistance and implementation of fluoride varnish programs. In 2008 Medicaid data revealed that 12,130 fluoride varnish applications were provided to 10,266 distinct recipients, with 1,392 billed by non-dental providers.

3. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers infants and children, including CYSHCN

The Oral Health Program continues to provide ongoing technical support to a wide variety of agencies, clinic systems and community based organizations related to fluoridation, program development, trends and best practices.

The Oral Health Program was the recipient of a Centers for Disease Control and Prevention Cooperative Agreement that has allowed for significant infrastructure building to take place within the program. Currently two of the three proposed funded positions have been filled, an oral health epidemiologist and a fluoridation specialist. The Agreement is a five year $300,00/year renewable award.

State GPR funding supports two rural dental clinics and one Technical College Dental Hygiene program for dental services to low income families as well as school based fluoride mouthrinse and fluoride supplement programs.

One time GPR supported funds totalling $3.2 million were awarded through a competitive process to 12 state organizations to enhance infrastructure and build capacity. The Chief Dental Officer and Public Health Dental Hygienist will be monitoring project progress.

4. Oral Health Surveillance--Infrastructure Building Services--Children including CYSHCN

In 2008 the Oral Health Program completed the second statewide "Make Your Smile Count" oral health assessment of third grade students. The data is in the process of final publication at this time.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dental Sealant Program			X	
2. Maternal and Early Childhood Oral Health			X	
3. Clinical Services and Technical Assistance			X	
4. Oral Health Surveillance				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Dental Sealant Program--Population Based Services--Children, including CYSHCN

The Oral Health Program is awaiting final decision on a grant proposal submitted to HRSA that would nearly triple current funding to support the statewide Seal-A-Smile school-based dental sealant program.

2. Maternal and Early Childhood Oral Health--Population-Based Services--Pregnant women and mothers

In 2009 we continue to train primary care providers and students in Early Childhood Caries prevention. One time dental access grants and GPR funds will continue to address and target women and children. Additionally, GPR funding supports two rural health dental clinics and one Technical College program that provide dental services to low income women and children.

The Oral Health Epidemiologist is in the initial stages of developing a statewide burden of oral disease document.

3. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers infants and children, including CYSHCN

One time dental access grants totalling $3.2 million were awarded to 12 agencies across the state to build infrastructure and increase capacity to serve women and children. GPR funds continue to support two rural health dental clinics and one Technical College.

We will continue to provide technical assistance to Children's Health Alliance for our joint effort of training dental professionals in treating CYSHCN.

c. Plan for the Coming Year

1. Dental Sealant Program--Population Based Services--Children, including CYSHCN

We anticipate the ability to continue to support at least 20 school-based, school-linked dental sealant programs through Seal-A-Smile. We intend to continue to aggressively seek additional sustainable funding to support this valuable project.

2. Maternal and Early Childhood Oral Health--Population-Based Services--Pregnant women and mothers

At least 300 primary care providers will be trained in Early Childhood Caries Prevention by the newly hired Fluoridation Specialist.

After holding a statewide Head Start Access to Oral Healthcare Forum we anticipate having ongoing issue-specific meetings and providing support for new policies and programs that will reduce the dilemma of Head Start families.

3. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers infants and children, including CYSHCN

We will continue to provide program and technical support to Children's Health Alliance for our joint project targeting dental health professionals, providing clinical and didactic training in the treatment of CYSHCN. The Oral Health Program will also be continually monitoring the one time dental access grant funds to ensure the target populations are being served.

State Performance Measure 3: *Percent of children, ages 6 months-5 years, who have age-appropriate social and emotional developmental levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			24	83.2	94.2
Annual Indicator		22.2	82.9	94.3	93.1
Numerator		1084	131	1103	1355
Denominator		4876	158	1170	1456
Data Source					SPHERE 2009.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94.2	94.3	94.3	94.4	94.4

Notes - 2008
Source: SPHERE program data, 2008.

Notes - 2007
In mid-2006, SPHERE changed to a new reporting method for collection of the ASQ:SE results, therefore, results were under reported in 2006. The 2007 increase in numbers of ASQ: SE screening results reflects improved reporting of results, as well as increased interest by LHDs in providing this screening program for young children.

Notes - 2006
Data was transferred from SPHERE to new ASQ:SE screens but not all data came over as separate from the developmental screens. Thus data for 2006 of ASQ:SE screenings completed and results are under reported. SPHERE correction will collect sound data during 2007 and with more screening programs occurring throughout the state, more ASQ:SE screenings will be completed. It is expected that numbers reflecting age-appropriate social-emotional development of children ages 6 months to 5 years in the state will increase and better reflect progress in Wisconsin. The MCH program will monitor this situation and review the data indicating achievement for SPM#4.

a. Last Year's Accomplishments

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

Home visiting programs to prevent child maltreatment include periodic screening of social emotional development using the ASQ: SE. Also 11 counties and one tribe used MCH block grant funds to screen children using the ASQ: SE. Referral for additional assessment occurs if needed. All MCH-funded programs report results of developmental assessments in SPHERE. For 2008, 1,456 of children age 6 months through age 5 years who received MCH program services were reported as having an ASQ: SE screen. Of those receiving an ASQ: SE screen, 94% were reported at age appropriate social/emotional developmental levels. One hundred seven children who were identified with concerns were reported as receiving some type of service for the identified concern and an additional 8 were enrolled in early intervention.

2. Education and training--Enabling Services--Children, including CYSHCN

During 2008, under the leadership of the University of Wisconsin-Extension, five all day ASQ and ASQ: SE tool training sessions were held and 67 persons attended. A training program specifically to meet needs of public health staff was piloted by staff of the Northern CYSHCN Regional Center and 28 persons attended.

3. Wisconsin Initiative for Infant Mental Health (WIIMH)--Infrastructure Building Services--Children, including CYSHCN

In late 2008, a joint statement and action steps were developed to bridge illness prevention and management, health promotion, public education and awareness efforts addressing mental and physical health, substance use and addictive disorders within a public health approach. This supports an integrated framework that looks at the life span and treatment continuum including prevention and early intervention. WI-AIMH is a strong partner in providing training of providers of service for early childhood populations. In 2008, 8 trainings were held with 320 attendees and 287 demonstrating increased capacity to promote social-emotional competence in children.

4. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

Since ECCS plan began implementation in September 2006, WI-AIMH assumed leadership of many activities. Key state partners including staff of State MCH Program have contributed to the work to improve systems of services for young children including fostering healthy social-emotional development. One of the key areas of focus within ECCS is health consultation for early care and education. During 2008, a local infant mental health coalition in Fond du Lac County convened an Infant Mental Health summit to improve local systems that support child social emotional competence.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Social-emotional Screening of Young Children	X			
2. Education and Training		X		
3. Wisconsin Initiative for Infant Mental Health				X
4. Early Childhood Comprehensive Systems Plan				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

During 2009, social emotional screenings at 11 DPH/MCH home visiting programs continues though programs transferred on July 1, 2008 to the new DCF for ongoing management. Additionally, 11 LHDs and one tribe are using MCH funds for ASQ: SE screening programs.

2. Education and training--Enabling Services--Children, including CYSHCN

Five training sessions promoting accurate use of ASQ and ASQ: SE are scheduled in 2009.

3. Wisconsin Initiative for Infant Mental Health (WIIMH)--Infrastructure Building Services--Children, including CYSHCN

WI-AIMH continues to support the work of state and local organizations in their programs for infants, young children, and their families. A subset of this workgroup is developing the policy, billing and training for DC0-3, coordinated by WI-AIMH, to allow providers to bill and obtain reimbursement for infant mental health interventions.

4. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

Implementation of Wisconsin ECCS plan due to a 9-month grant extension continues until May 31, 2009. An application for 3-year renewal was submitted March 11, 2009. Notice of grant award for continuation is pending.

c. Plan for the Coming Year

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

The state Title V MCH program will continue to support social emotional screenings in LHD programs using MCH funds. MCH will continue to advocate the use of the ASQ: SE tool to screen young children in the state for social-emotional competence.

2. Education and training--Enabling Services--Children, including CYSHCN

In cooperation with UW-Extension and other public health programs, the Title V MCH Program will continue in 2010 to ensure training is available to assure intended use of the ASQ and ASQ: SE tools are occurring.

3. Wisconsin Initiative for Infant Mental Health--Infrastructure Building Services--Children, including CYSHCN

The Infant and Mental Health DHS Leadership Team workgroup will continue to meet and collaborate to promote the efforts that advance infant mental health, promote knowledge and practice, and provide training to assure best practice. A focus in 2010 will be seeking endorsements from organizations throughout the state of the Joint Statement issued in 2009 and determine the actions of groups that support optimal physical, mental, social, emotional, and spiritual health.

4. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

ECCS uses a holistic approach to building systems that support a statewide network of child services in key ECCS areas through work with WECCP and during 2010, a key focus is on implementation of the revised Systems Plan. Linkages are expected with the new Governor's Advisory Council on Early Education and Care during an additional 3-year grant that is anticipated to begin June 1, 2009.

State Performance Measure 4: *Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			6	6	6
Annual Indicator	6.1	6.0	5.5	5.0	5.0
Numerator	8600	8148	7485	6721	6721
Denominator	1413635	1360112	1357139	1353148	1353148
Data Source					WI DCF 2009.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	6	6

Notes - 2008
Data issue: Data for 2008 are not available from the 'Wisconsin Department of Children and Families until 2010.

Notes - 2007
Data issue: Data for 2007 are not available from the Division of Children and Family Services until 2009.
Source: Wisconsin Department of Health and Family Services, Division of Children and Family Services, Office of Program Evaluation and Planning, Wisconin Child Abuse and Neglect Report, 2006 Data.

Notes - 2006
Source: Wisconsin Deparatment of Health and Family Services, Division of Children and Family Services, Office of Program Evaluation and Planning, Wisconin Child Abuse and Neglect Report, 2006 Data.

a. Last Year's Accomplishments
1. Family Foundations Home Visiting--Enabling Services--Infants and Young Children to age three years and their families

Home visiting programs for Prevention of Child Abuse and Neglect known as Family Foundations, was transferred on July 1, 2008 to the newly created Department of Children and Families (DCF) with the passage of Governor Doyle's 07-09 budget. The MCH program will support the transition of the programs to DCF until December 31, 2010.

2. Milwaukee Comprehensive Home Visiting, Empowering Families of Milwaukee--Enabling Services--Pregnant women, Infants and Young Children to age five years and their families

Empowering Families of Milwaukee home visiting program was transferred on July 1, 2008 to the DCF with the passage of Governor Doyle's 07-09 budget. The MCH program will support the transition of the program to DCF until December 31, 2010.

3. Milwaukee County Home Visiting Training Program--Enabling Services--Pregnant women, Infants and Young Children and their families

UW-Extension training contract to enhance skills and abilities for staff working in programs in Milwaukee County providing services to families of young children was transferred on July 1, 2008 to the DCF with the passage of Governor Doyle's 07-09 budget.
4. Prevention of Shaken Baby Syndrome--Population-Based Services--Pregnant women, Infants and Young Children and their families

During 2008, the MCH program continued activities to support messages of prevention to new parents in programs at birthing hospitals, county departments, home visiting and prenatal and postpartum case management programs, and maternity homes.

5. Increase surveillance capabilities for child maltreatment--Infrastructure Building Services--Pregnant women, infants, children and their families

The MCH Injury and Violence Prevention Program (IVPP) increased partnerships in 2008 and are now part of a collaborative group with the IRC and Children's Hospital of Wisconsin looking into additional surveillance options for child maltreatment.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family Foundations Home Visiting		X		
2. Milwaukee Comprehensive Home Visiting - Empowering Families of Milwaukee		X		
3. Milwaukee County Home Visiting Training Program		X		
4. Prevention of Shaken Baby Syndrome			X	
5. Increase Surveillance Capabilities for Child Maltreatment				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Family Foundations Home Visiting and Empowering Families of Milwaukee--Enabling Services--Infants and Young Children and their families

These two programs moved to the new Department of Children and Families (DCF) on July 1, 2008. The MCH program is supporting DCF to assure a smooth transition of programs and providers to changing expectations.

2. Increase surveillance capabilities for child maltreatment--Infrastructure Building--Infants and Young Children and their families

The Injury and Violence Prevention Program continues to evaluate appropriate surveillance strategies for child maltreatment.

c. Plan for the Coming Year
1. Family Foundations Home Visiting and Empowering Families of Milwaukee--Enabling Services--Infants and Young Children and their families

The MCH program will continue to support the DCF with home visitation programs during the transition and seek to coordinate activities with these programs and other MCH programs at local health department level.

2. Increase surveillance capabilities for child maltreatment--Infrastructure Building--Infants and Young Children and their families

Staff will continue to evaluate existing surveillance systems and consider new methods of collecting or linking data with the intent of forming a surveillance system for child maltreatment or analysis protocols for use on existing datasets. This will be done to the extent possible with the prevention programs for child maltreatment housed in DCF.

State Performance Measure 5: *Percent of children who receive coordinated, ongoing comprehensive care within a medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			52	52.5	53
Annual Indicator	51.2	51.2	52.5	52.5	52.5
Numerator	679854	679854	694021	694021	694021
Denominator	1327839	1327839	1321945	1321945	1321945
Data Source					SLAITS CSHCN.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53.5	55	56	58	58

Notes - 2008
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

Notes - 2007
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

Notes - 2006
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

a. Last Year's Accomplishments
1. Comprehensive Home Visiting--Enabling Services--Infants and Children

The home visiting program transferred to the DCF on July 1, 2008 and MCH is assisting in transition. This impacts the ability of the MCH program to continue to report on implementation of medical home within the programs.

2. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

Implementation strategies developed by the ECCS continue to impact the promotion of Medical Home. The WECCP website (http://www.collaboratingpartners.com/) was updated in 2008 to include information about medical home and linkages to the tool kit.

3. Early Hearing Detection and Intervention (EHDI)--Infrastructure Building Activities--Newborns

The CYSHCN Program continues to promote Medical Home outreach and implementation through its Regional Centers and local health departments. Staff updates to the WI Medical Home toolkit (www.wimedicalhometoolkit.aap.org) provide current information and implementation tools. The toolkit averages 431 hits per day, approximately 1,930 visits/month and 1,415 downloads/month. In addition, Wisconsin Sound Beginnings (WSB) is creating a WI EHDI quality improvement toolkit. While this toolkit will focus on EHDI it is based in part on the concepts of Medical Home implementation and contains specific information for the Medical Home provider.

4. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

PNCC providers match mothers with primary providers for prenatal care, postpartum, and inter-conception care and identify medical homes for the baby.

5. Early Screening--Infrastructure Building Activities--Infants and Children

Practice Based Developmental Screening Initiative -The CYSHCN Program in collaboration with the B-3 Personnel Development Project at the UW-Waisman Center, B-3 Program, and Regional CYSHCN Regional Centers conducted a "train-the-trainers" meeting for 14 primary care providers (PCPs) regarding developmental screening utilizing the AAP algorithm and implementing the ASQ in a practice-based setting. Each trained PCP in partnership with the Regional Centers and local B-3 is conducting trainings for other providers within their region. The Congenital Disorders Program promotes the concepts of medical home and care planning through its contracts with diagnostic/treatment sites. Contract requirements include identification of the medical home for patients; timely communication of specialty clinic visit information to the Medical Home, care planning and linkages to community services including the Regional Centers and Parent-to-Parent of WI.

6. Oral Health--Infrastructure Building Activities--Children

The Oral Health Program was the recipient of a CDC Cooperative Agreement that provided funding to support 3 additional oral health staff positions, specifically an epidemiologist, a fluoridation specialist and a dental sealant coordinator. One time dental access grants totaling $3.3 million were awarded to 12 statewide projects, including 4 FQHC's, to support infrastructure and capacity building targeting the BadgerCare+ population of women and children. In addition over 300 primary care providers were trained in Early Childhood Caries prevention and fluoride varnish implementation. Over 12,300 individual fluoride varnish applications were billed through Medicaid in 2008. Through a grant administered by Children's Health Alliance of Wisconsin targeting CYSHCN, 120 dental health professionals received training to increase awareness and skills related to treating CYSHCN.

7. Patient-at-Risk--Infrastructure Building Activities--Children

A pilot of the Patient-At-Risk system planned for rollout July 1, 2008 did not occur.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive Home Visiting		X		
2. Early Childhood Comprehensive Systems			X	
3. Early Hearing Detection and Intervention				X
4. Reproductive Health and Prenatal Care Coordination		X		
5. Patient-At-Risk				X

6. Oral Health				X
7. Early Screening				X
8.				
9.				
10.				

b. Current Activities

1. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

The MCH program continues to promote PNCC as a comprehensive program for prenatal, postpartum and interconceptional care with a goal of establishing medical homes for infants.

2. Early Screening--Infrastructure Building Activities--Infants and Children

CYSHCN Program staff through the WSB EHDI Learning Collaborative and Congenital Disorders Program contracts continues to update the WI Medical Home Toolkit and promote its use through its contracts with the Regional Centers, LHDs, and others.

3. Oral Health--Infrastructure Building Activities--Children and CYSHCN

Two CDC Cooperative Agreements support 2 oral health positions. The oral health epidemiologist & fluoridation specialist were hired. The Oral Health Program administrators/monitors the recent dental access awards and to ensure that the targeted population is served. Through a grant administered by CHAW for CYSHCN, 84 dental health professionals are trained to increase awareness and skills related to treating CYSHCN.

4. Patient-at-Risk--Infrastructure Building Activities--Children

Means to communicate health need of CYSHCN at time of emergency care is under review.

5. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

An ECCS continuing grant promotes system development work i.e., Medical Home for all young children.

c. Plan for the Coming Year

The concepts of Medical Home will be integrated into their framework as highlighted by the following activities:

1. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

The MCH program will continue to promote PNCC as a comprehensive program for prenatal, postpartum and interconceptional care with a goal of including a focus on establishing medical homes for mothers and infants.

2. Early Screening--Infrastructure Building Activities--Infants and Children

Congenital Disorders Program contracts continue to require identification of the medical home for patients; timely communication of specialty clinic visit information to the Medical Home, care planning including transition to adult services, and linkages to community services. CYSHCN Program staff will continue to update the WI Medical Home Toolkit and promote its use through its contracts with the Regional Centers and with local health departments and others. Through the WSB EHDI Learning Collaborative, the EHDI toolkit will be updated to include new QI tools/products developed by the EHDI QI teams and WSB.

3. Oral Health--Infrastructure Building Activities--Children and CYSHCN

Three trainings will be held for dental health professionals to increase knowledge and skills in treating CYSHCN. In addition, grantees will continue to be monitored to ensure dental homes for all children.

4. Patient-at-Risk--Infrastructure Building Activities--Children

The Title V, MCH Program will continue involvement with activities to explore means to communicate health need of CYSHCN at time of emergency care.

5. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

A continuing ECCS grant was submitted March 11, 2009 to support continued work on the five components of a system of services for young children including screening programs and the promotion of medical home.

State Performance Measure 6: *Percent of children less than 12 years of age who receive one physical exam a year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	80.5	81	81.5	81.5
Annual Indicator	75.7	83.0	77.1	78.2	78.2
Numerator	618000	677000	641000	630000	630000
Denominator	816000	816000	831000	806000	806000
Data Source					WI DHS BHIP 2009.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	81.5	81.5	81.5	81.5	81.5

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2007. Madison, Wisconsin: 2009.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2006. Madison, Wisconsin, 2008. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance status, and use of health services among Wisconsin residents.
Numerator: Weighted data. Denominator: Weighted data.

a. Last Year's Accomplishments

The performance measure relates to Wisconsin's Priority Need - Access to Primary and Preventive Health Services, and is identified in Healthiest Wisconsin 2010, the state's public health plan. Special access issues exist for those living in rural communities, seasonal and migrant workers, persons with special health care needs, the uninsured and underinsured, homeless persons and low income members of racial or cultural minority groups.

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

The annual health exam activity is a direct health care service for children under age 21, including children with special health care needs. The target groups for services funded by the Title V block grant are children who are uninsured or underinsured. MCH provided funds to 11 LHDs in 2008 for well-child exams for children under age 21 years, including those with special health care needs. As reported in SPHERE for 2008 contracts, 1,258 unduplicated clients aged 0-12 years were reported as receiving physical exams. In 2008, 78.1% of children under age 12 years accessed at least one physical exam per the Family Health Survey which is a slight increase from the previous year but less than the high of 83% reported in 2005.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

BadgerCare Plus began enrolling families on February 1, 2008. It is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. Enrollment continues to increase with 80,845 children and youth enrolled since implementation.

3. "Covering Kids" Program Funded by the Robert Wood Johnson (RWJ) Foundation--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

"Covering Kids" Program continued coalition activities to improve outreach as BadgerCare Plus was implemented in 2008. Recently Covering Kids has shifted its focus to the CHILD Project, which seeks to develop capacity within Wisconsin's public schools to provide needed information and assistance for children and their families who lack health insurance and may be eligible for coverage under BadgerCare Plus, Wisconsin's public health insurance program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Well-Child Exams	X			
2. Governor's BadgerCare Plus Initiative		X		
3. "Covering Kids" Program		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

For 2009 consolidated contracts, 4 LHDs again submitted objectives to provide or assure access to primary preventive exams; this is a decrease of 63%.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

BadgerCare Plus outreach is currently being enhanced with a grant from Robert Wood Johnson Foundation to support enrollment and retention. This should improve prospects for preventive services including health and oral exams all children in the state.

3. "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Wisconsin "Covering Kids and Families" Program continues with funding grants from both state medical schools and from dollars from DHCAA. Activities include support for coalitions to increase outreach for uninsured children and their families and to enroll them in state supported health insurance programs, such as BadgerCare.

c. Plan for the Coming Year

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

Title V MCH/CYSHCN Program remains committed to improving access to health care so that primary, preventive health care is available to young children. The Title V MCH/CYSHCN Program will continue to provide funds through 2010 per the consolidated contract process promoting primary, preventive health care to young children who are uninsured or underinsured. Since the LHDs use these funds according to general program guidelines and to address local identified needs, the impact of MCH funds supporting a provision of primary, preventive health care is gap filling.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's planned expansion to the Wisconsin BadgerCare Program that provides an opportunity for health insurance for all children in the state. The MCH program will have an opportunity to outreach to pregnant women, mothers, infants, children, children and youth with special health care needs, and their families to improve access to health care coverage and connect to community programs enrolling families. This should increase access to primary preventive health exams for young children.

3. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

"Covering Kids" Coalition activities are ongoing and is supported by the MCH Program. Through the efforts of Covering Kids, it is expected that Medicaid enrollment will increase as BadgerCare Plus fully funds all children.

State Performance Measure 7: *Percent of women who use tobacco during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	15.2	15	14.5	14	13.5

Annual Indicator	14.0	13.4	14.9	14.9	14.9
Numerator	9812	9503	10715	10843	10843
Denominator	70012	70719	72114	72560	72560
Data Source					WI DHS/DPH/BHIP 2009.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13.5	13.5	13	13	13

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2009.

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issue: Data for 2007 are not available from the Bureau of Health Information and Policy until 2008.
Source: There were 70,302 births in Wisconsin in 2006. Birth certificate data indicate that 61,399 reported they did not smoke during pregnancy; 10,715 reported smoking, and there were 188 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2008.

a. Last Year's Accomplishments
Relates to Priority Need #7 - Smoking and Tobacco Use. In 2007, birth certificate data indicated 14.9% of Wisconsin women smoked during pregnancy, the same rate as 2006.

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers and infants

The Title V Program funded 36 LHDs totaling 44 objectives addressing a variety of perinatal-related issues.

As reported for 2008 in SPHERE, of those women who received a prenatal assessment utilizing both Title V funds and Medicaid PNCC 49% reported smoking before pregnancy, 33% reported smoking during pregnancy, and 60% reported decreasing smoking during pregnancy. Other SPHERE data show of the women whose smoking changed during pregnancy and were followed, 76% reported maintenance of non-smoking status and 44% reported exposure to secondhand smoke in their household.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). In 2008 1,502 women enrolled in the First Breath Program. Between 2006 and 2008 there was a 48% increase in African American participants in the First Breath Program; a result of concentrated expansion and continued support and technical assistance to sites in Southeastern Wisconsin. A prenatal quit rate of 34% exceeded the program goal of 25%. 79.7% of the program's participants were Medicaid recipients in 2008.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers and infants

The focus of this group is on tobacco use and cessation among women of reproductive age. Due to lack of resources to support this effort, this activity will be addressed under the First Breath Program. The results of the clinician survey will determine priority areas for provider education.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

Through the Medicaid PNCC and MCH-funded Perinatal Care Coordination Programs pregnant women identified as high risk for adverse pregnancy outcomes receive strength based individual care in the prenatal period and postpartum. One of the individual focuses is tobacco use and cessation. Individuals are referred to the First Breath Program. In SFY 2008 949 women reported making a change in tobacco use during the prenatal and postpartum period and 76% of those women served by these programs reported not smoking in the postpartum period.

5. Preconception Services--Enabling Services--Pregnant women, mothers and infants

Infant Death Center of Wisconsin (IDC) facilitated a safe sleep/smoking cessation workgroup for a coalition of representatives from Milwaukee hospitals. The WAPC Preconception Committee surveyed healthcare providers about preconception practices and knowledge including smoking cessation and the preconception tool kit for use in clinics was disseminated.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Women and Tobacco Team (WATT)		X		
4. Prenatal Care Coordination (PNCC)		X		
5. Preconception Service		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Serivces--Pregnant women, mothers and infants

The Title V program funded 55 LHDs totaling 83 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

For CY 2009, 101 First Breath sites are participating in the program and 373 women have been enrolled. First Breath participants continue to be predominately of non-Hispanic white race, low income and low education level.

3. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

Education sessions for the Great Beginnings Start Before Birth curriculum are being offer to all

PNCC providers regionally.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The IDC of Wisconsin continues working with the safe sleep/smoking cessation workgroup and the community on education for creating smoke free environments. The WAPC preconception committee continues to plan for educating clinical providers on preconception health with a smoking cessation focus.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Serivces--Pregnant women, mothers and infants

Due to the complex nature of smoking during pregnancy, this topic will continue to be a priority for the Title V Program. The provision of Title V funds and appropriate resources will be be determined as a result of the Needs Assessment.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath Program. This partnership will focus on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, continue expansion efforts in Southeastern Wisconsin and increase enrollment at First Breath Tribal Clinics.

3. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers and infants

The Medicaid PNCC and the MCH-funded perinatal care coordination programs will continue to support the comprehensive strength based services to women during the prenatal and postpartum period. The Great Beginnings Start before Birth curriculum will be offered statewide 1-2 times as needed. Through the regional PNCC provider groups data collected on key outcomes will be shared amongst LHDs with discussion on plans for improvement. Healthy Baby Action Teams will work to identify and possibly pilot innovative uses of technology to educate and send messages to pregnant women.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

Through local coalitions in 4 high risk communities and Native American tribes the Infant Death Center of Wisconsin will continue to provide preconception/interconception information that focuses on women's health, including smoking cessation. IDC will collaborate with the ABC's for Health Families project in Milwuakee to develop and disseminate social marketing messages on tobacco use during pregnancy and second hand smoke for infants. The WAPC preconception committee will continue to develop an educational tool for clinical providers on preconception health including smoking cessation. Additionally they are focusing on preconception materials for men.

State Performance Measure 8: *Percent of children, ages 2-4, who are obese or overweight at or above the 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	10.8	12	12.1	11.8	11.6
Annual Indicator	13.3	12.9	13.0	13.1	13.6
Numerator	6893	6648	6717	6764	7599
Denominator	51825	51410	51667	51636	55875
Data Source					CDC PedNSS 2009.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.5	12.4	12.3	12.2	12.1

Notes - 2008
Source: 2008 Pediatric Nutrition Suverillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: 2006 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting (PBC), 14 LHDs worked to create environments that promote breastfeeding, healthy eating, physical activity, and a healthy weight. These activities are linked to Healthier Wisconsin 2010, the Wisconsin Nutrition and Physical Activity State Plan and local community health improvement plans. Many provided educational, policy and environmental change opportunities in community, worksite, school, healthcare, childcare and afterschool settings. Two LHDs worked with childcare to implement "Color Me Healthy" curriculum reaching over 270 pre-school children. A LHD focused on implementing a worksite wellness program in 2 school districts reaching 215 employees. Several LHDs provided education on healthy eating and being physically active through events, at the county fair, and the media.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs promoted nutrition and physical activity in their communities through a variety of campaigns. This includes a Fun/Run Walk with 113 participants with 160#'s of food donated to the food pantry; a Turn Off TV Week challenge with 519 participants; a Walk to School Challenge with 9,337 participants from 10 schools in the community; a community "Saturday Morning Walk" that increased access to public facilities for physical activity; a multi-worksite wellness challenge; and a walk/bike to work challenge with 438 miles walked, 288 miles biked and 58,276 calories burned.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs improved the nutrition and physical activity environment in their communities. Strategies implemented included community/coalition capacity building and

planning, walkability/bikeability surveys, community health improvement plan development, worksite assessments, the Governor's School Health Award criteria, breastfeeding support at work, sustainability planning, outreach to key stakeholder in the community, and a Healthy Communities Award to recognize youth.

4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing and managing overweight and obesity. There were ~40 local coalitions focused on obesity prevention efforts in 2008. Key partnerships that were developed/maintained by the coalitions/LHDs included: recruiting and retaining coalition members, schools, worksites, childcare, farmers' markets, UW-Extension, Master Gardeners and Food Preservers, WIC, YMCA, after-school programs, media, minority organizations and parent groups. In many examples the work funded by MCH and through the partnerships has been able to leverage additional grant funds, in-kind services and support.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plans				X
4. Nutrition and Physical Activity Coalitions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 10 LHDs are creating environments that promote breastfeeding, healthy eating, physical activity and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs are promoting nutrition and physical activity in their community. These include a Fun Walk/Run, Safe School Routes, Turn off TV Week, Healthy Community Award.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs are improving the nutrition and physical activity environment and building the infrastructure. Strategies include: walkability/bikeability surveys, childcare environment assessments, Safe Routes to School, school wellness, assessment of breastfeeding services, worksite wellness, farmers markets, Got Dirt? Garden Initiative, and childcare curriculum.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of

2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 38 local coalitions focused on nutrition, physical activity & obesity prevention.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting system, LHDs will be encouraged to choose a template objective that provides focused effort related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreased consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases. Both plans will be updated.

2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the Wisconsin Nutrition and Physical Activity State Plan. Campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition, Physical Activity and Obesity Program will disseminate resources to LHDs, coalitions, and community-based organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will continue to promote the use of the State Plan as a "blueprint" for activities to prevent and manage overweight among children and their families.

4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~38 local coalitions who will focus on preventing overweight, improving nutrition and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, safe neighborhoods, access to healthy food as well as food security and hunger. An annual survey will be conducted to capture current capacity to implement interventions, identify training and resource needs and highlight successes.

Key partners include: the WIC Program, DPI programs, the Child and Adult Care Feeding Program, Dept. of Transportation, Dept. of Agriculture, UW-Extension, Minority Health Program, LHDs, and community coalitions.

State Performance Measure 9: *Ratio of the black infant mortality rate to the white infant mortality rate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	2.4	2.4	3.7	2.9	2.9
Annual Indicator	4.3	2.7	3.5	2.7	2.7
Numerator	19.2	15	17.2	14.5	14.5
Denominator	4.5	5.6	4.9	5.3	5.3
Data Source					WI DHS/BHIP 2009.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.7	2.7	2.7	2.6	2.6

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issue: Data for 2006 are not available from the Bureau of Health Information and Policy until 2008.
We revised our objectives to reflect the white infant mortality rate of 2004 which was 4.5/1000 and a random fluctuation, therefore, the disparity ratio for 2004 was significantly greater than other years.

a. Last Year's Accomplishments
Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative remains one of the Department of Health Services (DHS) highest priorities. See www.dhs.wisconsin.gov/healthybirths/ for a comprehensive overview of the initiative. Highlights of accomplishments are provided below.

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

An article was written and published with the Bureau of Health Information and Policy and the Minority Health Program on Wisconsin Healthy Birth Outcomes in Journal of Public Health Management and Practice (Nov. 2008).

The 2008-2011 Framework to Action to Eliminate Racial and Ethnic Disparities was revised and posted on the web site at www.dhs.wisconsin.gov/healthybirths/.

The ABCs for Healthy Babies social marketing project conducted 18 focus groups with African American mothers, fathers and grandmothers. See the Final Report on the web site listed above.

Statewide Advisory Committee meetings were held in March, August, and November. The August meeting was held in Kenosha, in conjunction with the Kenosha Infant Mortality Coalition. Over 150 people attended and this generated media, Medicaid, and local attention to the issue.

The MCH program was a successful applicant for the First Time Motherhood/New Parents Initiative from MCHB/HRSA and is building on the ABCs for Healthy Babies project to implement the ABCs for Healthy Families: A Social Marketing Campaign for the Integration of the Life-Course Perspective. "ABCs" refers to "applied behavioral change".

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

We collaborated with the First Breath program on reaching women of color. The Program Director is on our technical assistance advisory group for the ABCs for Healthy Families project and we will collaborate further with them on social marketing efforts.

Collaboration with the Milwaukee Family Services Integration continued. (See description in the State Overview Section on W-2.)

The Evidence-based Practices Workgroup has expanded its selected topics for research to 28 and has been drafting its recommendations.

We participated on Medicaid P4P Birth Outcomes Workgroup and collaborated in a recommendation for a high risk registry for pregnant women and the submission of comprehensive plans by the HMO managed health care plans.

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

The Data Workgroup expanded its membership and selected the categories of measurable indicators to track progress as part of its draft recommendations.

The Empowering Families of Milwaukee home visiting program was transitioned to the Department of Children and Families and the Infant and Young Child Nurse Consultant continued as a liaison on the project.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

Wisconsin received funding from Kellogg for the Partnership to Eliminate Disparities in Birth Outcomes (PEDIM), sponsored by MCHB, Healthy Start, and CityMatCH. The Policy and Funding Workgroup took this project on and members participated on either the core travel team or expanded team. They began preparing recommendations, such as a Children's Zone, a Community Health Improvement Trust, and Public Health Partnership Plan.

The DHS Secretary has attended two of the Statewide Advisory Committee meetings in the absence of the State Health Officer and is regularly briefed on the progress of this initiative.

Close collaboration continued with the UW Partnership Program (WPP) on funding for a special initiative to reduce disparities in birth outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Communication and Outreach			X	
2. Evidence Based Practices		X		
3. Data Monitoring and Evaluation				X
4. Policy and Funding				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

New State Health Officer continues to sponsor intiatiative and 3 meetings will be held. Workgroup recommendations are being drafted. ABCs for Healthy Families is being implemented.

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

Ongoing monitoring and technical assistance to the MCH statewide projects continues. Recommendations from Evidence-based Practices workgroup are being drafted. Applied for Project Launch funding to collaborate with City of Milwaukee Health Department and ECCS Program to expand evidence-based/best practices to eliminate racial and ethnic health disparities among vulnerable children ages 0-8. The City of Racine Health Department receives technical assistance for reducing fetal and infant deaths. Leading efforts for a regional FIMR Program and seeking funding. Continue collaboration with Pay-for-Performance.

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

The Data workgroup is drafting recommendations. Partnering with Madison/Dane Co. Pubic Health Dept and the UW on study of improved infant mortality.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

Implementing PEDIM. Collaborating with the UW Partnership Program on funding for special initiative on reducing disparities in birth outcomes.

c. Plan for the Coming Year

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

Statewide Advisory Committee will review and finalize all workgroup recommendations and final report will be posted on the web and disseminated to DHS Secretary and other interested parties. Continue to implement ABCs for Healthy Families social marketing campaign and outreach to providers and consumers on life-course perspective messages and services. Collaborate with UW Partnership Program for continuation of social marketing efforts.

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

Monitoring and technical assistance to the MCH statewide projects will continue. Dissemination of recommendations from Evidence-based Practices workgroup will begin, including through the Medicaid program. Continue to collaborate with City of Milwaukee Health Department and explore further collaboration with the ECCS program to expand evidence-based/best practices to eliminate racial and ethnic health disparities among vulnerable children ages 0-8. Continue to provide City of Racine Health Department and its partners, technical assistance on reducing fetal and infant deaths. Continue efforts to create a regional FIMR Program and seeking funding. Continue collaboration with Pay-for-Performance and high quality medical care for Medicaid women.

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

Data workgroup will monitor and track final indicators as outlined in its recommendations. Continue to partner with Madison/Dane Co. Pubic Health Dept and UW on Study of Improved

Infant Mortality.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

We will continue close collaboration with the Medicaid Program to assure policy changes are implemented for healthy birth outcomes through the Pay-for-Performance, PNCC, and other Medicaid Programs. We will continue ongoing collaboration with the Kellogg-funded PEDIM through the travel core team and expanded team, including efforts to join with ongoing fatherhood initiative in Milwaukee.

Chief Medical Officer and Deputy Director of SERO are official members of the Steering Committee of the UW Partnership Program for funding the special initiative on reducing disparities in birth outcomes. We will actively participate in the guidance for the release of these funds and provide technical assistance to members of the local communities who will be writing strategic plans for these funds. The recommendations of the policy and funding workgroup will be finalized and considered once the report is disseminated (as mentioned under Communications and Outreach). We will continue, with partners, to seek other public and private funds to implement Framework for Action strategies.

State Performance Measure 10: *Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	21	20.5	20.5	20	20
Annual Indicator	23.5	25.7	24.5	23.1	23.1
Numerator	96	105	99	93	93
Denominator	409081	409101	404777	402172	402172
Data Source					WI DHS/BHIP 2009.
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	22	22	22	22	22

Notes - 2008
Data issue: Data for 2009 will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http:// dhfs.wisconsin.gov/wish/Mortality Module, accessed 04/16/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http:// dhfs.wisconsin.gov/wish/Mortality Module, accessed 04/29/08.

a. Last Year's Accomplishments
1. Educational Activities--Enabling Services--Adolescents

We continued to encourage partners locally to implement programs that address motor vehicle safety and injury prevention.

2. Legislation--Population-Based Services--Adolescents

Legislation was monitored and compared to other states and best-practice to begin to identify the impact on WI teens.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

The Injury and Violence Prevention Program (IVPP) and DOT continued to make motor vehicle crash data more accessible to agencies and the general public. Injury WISH modules are inclusive of motor vehicle related information for hospitalizations, deaths, and emergency department visits. Ongoing education and outreach to promote the availability of this query system and other data resources were carried out.

4. Injury Prevention Coordinating Committee (ICC)--Infrastructure Building Services--Adolescents

The Injury Prevention Coordinating Committee has been put on hold to restructure in order to work towards a state plan specific for injury and violence prevention which will include motor vehicle prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educational Activities		X		
2. Legislation			X	
3. Local Needs Assessments				X
4. Injury Coordinating Committee (ICC)				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Educational Activities--Enabling Services--Adolescents

In order to decrease the incidence of deaths due to motor vehicle crashes, education is continuing with our many partners including local and state.

2. Legislation and Policy Changes--Population-Based Services--Adolescents

Enactment and enforcement continues to be a strong method of impacting this performance measure and ongoing evaluation of the most recent policies will be done in Wisconsin in conjunction with academic and advocacy partners.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

Staff continues to work with local agencies to obtain county-specific data and technical support. The IVPP and DOT continue to make motor vehicle crash data more accessible to agencies and the general public. We are encouraging local CDR teams to enter data into the national CDR data system to increase our data sources as well.

4. Child Death Review (CDR)--Infrastructure Building Services--Adolescents

Promotion and support of local CDR teams is ongoing including providing assistance with utilizing the national data base to collect local data, providing technical assistance and training on utilizing CDR data for prevention and identifying evidence-based prevention strategies including those related to teen driving.

c. Plan for the Coming Year

1. Educational Activities--Enabling Services--Adolescents

In order to decrease the incidence of deaths due to motor vehicle crashes, education will continue with our many partners including local and state.

2. Legislation and Policy Changes--Population-Based Services--Adolescents

Enactment and enforcement continues to be a strong method of impacting this performance measure and evaluation of the most recent policies will be utilized in conjunction with academic and advocacy partners to identify improvments or next steps.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

Staff will continue to work with local agencies to provide county-specific data and technical support. The IVPP and DOT continue to make motor vehicle crash data more accessible to agencies and the general public. We will continue work with local CDR teams to enter data into the national CDR data system to increase our data sources as well.

4. Child Death Review (CDR)--Infrastructure Building Services--Adolescents

Promotion and support of local CDR teams will continue including providing assistance with utilzing the national CDR data base to collect local data, providing technical assistance and training on utilizing CDR data for prevention and identifying evidence-based prevention strategies including those related to teen driving.

E. Health Status Indicators

Introduction

2005 data are required by the TVIS for the Health Status Indicators (HSIs), forms 20 and 21 for the 2007 Title V Block Grant Application; however, for the majority of these indicators (with the exception of program data for chlamydia [#05A and #05B], 2005 data are not available. Therefore, we used the most recent available data (in most cases 2004 data) as estimates for 2005 and so indicated in a data note. Data for #01A - #03C are maintained by the DHFS, DPH, Bureau of Health Information and Policy, Vital Records Section; 2005 data will not be available until 2007. Since September 2003, collection of hospitalization data for the unintentional and non-fatal injury indicators (#04A - #04C) is the responsibility of the Wisconsin Hospital Association, and access by DHFS to recent discharge data depends on a data use agreement.

/2010/ 2008 data are required; however, for the majority of these indicators (with the exception of program data for chlaymdia [#05A and #05A], 2008 data are not available. We used the most recent data available (usually 2007 data) as provisional data for 2008 (so indicated in a data note). Data for #01A - #04C are maintained by the DHS, DPH, Bureau of Health Information and Policy and, 2008 data will not be available until 2010. //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.0	7.0	6.8	7.0	7.0
Numerator	4907	4992	4994	5089	5089
Denominator	70131	70934	73202	72757	72757
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/09/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/11/2008.

Narrative:
The percent of live births weighing less than 2500 grams has increased gradually since 2000 from 6.5% to 7.0% in 2004; Wisconsin's percent of low birth infants in 2004 is lower than the U.S. preliminary rate of 8.1% in 2004. Twins or other multiple births made up 26.1% of all low birthweight births in 2004.

/2008/ Compared with the overall incidence of low birthweight in 2005 (7.0%), higher percentages of low birthweight infants were born to: a) Mothers who received no prenatal care (22.6%), b) Mothers less than 15 years old (14.0%), c) Non-Hispanic black women (13.7%), d) Women who smoked during pregnancy (11.4%), e) Women who were unmarried (9.3%), and f) women with less than a high school education (9.3%). In 2005, 10.6% of infants born to mothers less than 18 years of age weighed less than 2,500 grams at birth compared with 6.9% among mothers age 18 and older. Among premature infants, 42% were of low birthweight. Twins or other multiple births made up 25.9% of all low birthweight births in 2005. Low birthweight is a key long term outcome for evaluation of the Medicaid prenatal Care coordination benefit and the Empowering Families of Milwaukee home visiting program.

Low birthweight and prematurity have been identified as major contributors (along with unsafe infant sleep) to the disparities in birth outcomes among Wisconsin's racial and ethnic minority populations. A number of the action steps within the Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes include educational efforts and interventions to prevent these conditions, such as smoking cessation for pregnant women, screening and treatment of infections during pregnancy, and educating women about the signs and symptoms of preterm labor. The Medicaid Program produced a fact sheet on Medicaid costs associated with low birthweight births. See Supporting Data at www.dhs.wisconsin.gov/healthybirths/. Future

program efforts will include raising public awareness, promoting best practices among providers and consumers, and seeking funding for culturally-appropriate and effective messages and interventions. We will continue to join others, such as the March of Dimes and the Association of Women's Health, Obstetric and Neonatal Nurses, in their conferences and summits on prematurity. //2008//

/2009/ See #01B. //2009//

/2010/ See #01B. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.5	5.4	5.4	5.5	5.5
Numerator	3727	3699	3754	3859	3859
Denominator	67856	68655	70045	70499	70499
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/09/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/11/2008.

Narrative:
The percent of live singleton births weighing less than 2500 grams has remained about the same since 2002 when it was 5.2%; in 2004, it was 5.3%. In 2004, higher percentages of low birthweight infants were born to: mothers who receive no prenatal care (23.1%), non-Hispanic black women (13.7%), women who smoked during pregnancy (11.2%), teens less than 15 years old (14.3%), women who were unmarried (9.6%), and women with less than a high school education (9.0%).

/2008/ See #01A. //2008//

/2009/ Compared with the overall incidence of low birthweight in 2006 (6.9%), higher percentages of low birthweight infants were born to: a) Mothers who received no prenatal care (21.3%), b) Mothers less than 15 years old (7.6%), c) Non-Hispanic black women (13.5%), d) Women who

smoked during pregnancy (10.8%), e) Women who were unmarried (9.2%), and f) Women with less than a high school education (8.8%). In 2006, 11% of infants born to mothers less than 18 years of age weighed less than 2,500 grams at birth compared with 6.8% among mothers age 18 and older. 42% of premature infants were of low birthweight. Twins or other multiple births made up 24.8% of all low birthweight births in 2006. Low birthweight remains a key long term outcome for evaluation of the Medicaid Prenatal Care Coordination benefit and the Empowering Families of Milwaukee home visiting program.

Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. DPH awarded Minority Health Program funding for consumer and community focus group development and testing of culturally appropriate messages for public information campaigns on the leading causes of poor birth outcomes for African American women. The Data Workgroup of the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities is choosing low birthweight as one indicator to track. The Evidenced-based Practices Workgroup has chosen to review the literature for a number of related topics (see SPM #9). //2009//

/2010/ Compared with the overall incidence of low birthweight in 2007 (7.0%), higher percentages of low birthweight infants were born to: a) Mothers who received no prenatal care (22 %), b) Non-Hispanic black/ African American women (13.5%), c) Women who smoked during pregnancy (11.5%), d) Mothers less than 15 years old (11.3%), e) Women who were unmarried (9.4%) and f) Women with less than a high school education (9.2%). In 2007, 10.4 % of the infants born to mothers less than 18 years weighed less than 2500 gms at birth compared with 6.9% among mothers age 18 and older. 42% of the premature infants were low birthweight. Twins or other multiple births made up 24.2% of all low birthweight births. DHS has identified low birthweight as an executive performance measure. See HSCI #5 for more information. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.2	1.3	1.2	1.2	0.1
Numerator	869	925	914	870	870
Denominator	70131	70934	73202	72757	727575
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/09/2009.

Notes - 2006

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/11/2008.

Narrative:
In 2004, the percent of live births weighing less than 1500 grams was 1.2% compared to 1.3% in 2003.

/2008/ In 2005, the percentage of very low birthweight infants in Wisconsin weighing less than 1500 grams was 1.3% among all births, and 1.0% of births to whites, 1.3% of births to Hispanics, 3.5% of births to blacks, 1.3% of births to American Indians, and 1.2% of births to Laotian/Hmong.

The Title V program has used the Perinatal Periods of Risk (PPOR) model to analyze fetal and infant mortality data (see PPOR Charts and Graphs on the follow page). The PPOR model identifies four categories based on birthweight and time of death: Maternal Health/Prematurity (fetal, neonatal and infant deaths, 500-1499 grams), Maternal Care (fetal deaths, 1500+ grams), Newborn Care (neonatal deaths, 1500+ grams), Infant Health (postneonatal deaths, 1500+ grams). Data in these categories is compared to a reference population with good outcomes (non-Hispanic white women in Wisconsin, >20 years old with 13+ years of education). The difference identifies the number of excess deaths and percent contribution of excess deaths. The PPOR analysis based on 2002-2004 Wisconsin data identified fetal and infant deaths with birthweights less than 1500 grams accounted for 34% of the excess deaths for the population as a whole, 50% of excess deaths for blacks, 39% of excess deaths for Hispanics, 26% of excess deaths for whites, 51% of excess deaths in the city of Milwaukee, and 50% of excess deaths for blacks in the city of Milwaukee. Very low birthweight is a significant factor in the disparities in infant mortality rates for blacks in Wisconsin. //2008//

/2009/ In 2006, the percentage of very low birthweight infants in Wisconsin weighing less than 1,500 grams was 1.3% among all births, and 1.0% of births to Whites, 1.3% of births to Hispanics, 3.0% of births to Blacks, 1.7% of births to American Indians, and 1.1% of births to Laotian/Hmong. The disparity between Black infants and White infants is greater for very low birthweight than for low birthweight. In 2004-2006, African American infants were more than three times as likely to be born at very low birthweight as were white infants.

Public Health of Madison and Dane County is reporting a dramatic decline over the past five years in African American infant mortality, coinciding with a marked decline in extreme prematurity. //2009//

/2010/ See #02B. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.9	1.0	1.0	0.9	0.9
Numerator	634	661	683	653	653
Denominator	67856	68655	70045	70499	70499
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/09/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 4/16/2008.

Narrative:
The percent of live singleton births weighing less than 1500 grams was .9% in 2004, a slight decrease from 1.0% which was the rate from 2000-2003.

/2008/ See #02A. //2008//

/2009/ See #02A. //2009//

/2010/ In 2007, the percentage of very low birthweight infants in Wisconsin weighing less than 1,500 gms was 1.2% among all births, and 1.0% of births to Whites, 2.9% of births to blacks/African Americans, 0.5% of births to American Indians, 1.2% of births to Hispanics, and 0.8% of births to Laotian/Hmong. The disparity between black/African American and White infants is even greater for very low birthweight than for low birthweight. In 2005-2007, African American infants were more than three times as likely to be born at very low birthweight as were white infants. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.2	9.7	7.4	9.5	9.5
Numerator	77	103	80	103	103
Denominator	1073253	1062878	1078955	1086602	1086602
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 4/11/2008.

Narrative:
The rate of unintentional injuries among children aged 14 years and younger fluctuated during the past 5 years. The rate of deaths in 2004 was 7.3, compared to 8.1 in 2003. From 2001 to 2004, the largest number of deaths was from occupants involved in motor vehicle crashes, followed by death from suffocation.

/2008/ The rate of unintentional injury death among children ages 14 years and younger fluctuated during the past 5 years. The rate of death in 2005 was 9.7, compared to 7.2 in 2004. This rate increase is a result of 26 additional injury-related deaths in 2005 as compared to 2004. While the rate increase is not statistically significant, the death of 26 more children is cause for concern. The leading cause of unintentional injury deaths continues to be due to motor vehicle crashes, but much of the increase of unintentional injury fatalities in 2005 was an increase in deaths due to suffocation. //2008//

/2009/ In 2006, the rate of unintentional injury deaths among children 14 years of age and younger was 7.2 per 100,000. This is a decrease from 2005, when the rate of death was 9.7 per 100,000. This rate decrease represents 23 fewer unintentional injury deaths in the target population. Motor vehicle-related deaths were not the most common cause of deaths as has been the trend. Rather, the most common cause of these deaths was suffocation, followed by motor vehicle-related deaths. //2009//

/2010/ In 2007, the rate of unintentional injury among children 14 years of age and younger was 9.5 per 100,000 persons. Leading cause of death in this category was suffocation (n=34), followed by motor vehicle-related traffic crashes (n=27) and poisoning (n=10). //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.9	2.8	1.8	2.5	2.5
Numerator	31	30	19	27	27
Denominator	1073202	1062878	1078955	1086602	1086602
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/,Injury Mortality Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/,Injury Mortality Module, accessed 4/11/2008.

Narrative:
Aside from a slight increase in 2002 to 3.8, the rate of unintentional deaths from motor vehicle crashes among children aged 14 years and younger has steadily decreased from 3.3 in 2001 to 2.9 in 2004.

/2008/ The rate of unintentional deaths from motor vehicle crashes among children ages 14 years and younger has remained relatively consistent over the past five years. There was a slight increase from 2.5 per 100,000 population in 2004 to 2.8 per 100,000 population in 2005, due to an additional three deaths in 2005. //2008//

/2009/ The rate of unintentional deaths from motor vehicle crashes among children ages 14 years and younger was 1.8 per 100,000. This is a decrease from 2.8 per 100,000 in 2005. //2009//

/2010/ Rate of unintentional deaths from motor vehicle crashes among children ages 14 years and younger was 2.5 per 100,000. This is a slight increase from 2006. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.5	26.3	25.7	24.9	24.9
Numerator	209	216	209	199	199
Denominator	819912	820561	812433	797824	797824
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 4/11/08.

Narrative:
Motor vehicle accidents continue to be the leading cause of death for youth 15 through 24 years old. In 2004, the rate of death due to motor vehicle accidents was 26.0, a slight decrease from 30.0 in 2003. Overall, the rate has fluctuated since 2001 and there is no discernable trend.

/2008/ In 2005, the rate of death due to motor vehicle crashes in youths ages 15 to 24 years was 26.3 per 100,000 population, a slight increase from 2004. However, there is no significant trend or change in rate over the past five years. //2008//

/2009/ In 2006, the rate of death due to motor vehicle crashes in youths ages 15 to 24 years was 25.7 per 100,000 population. This rate represents 7 fewer deaths than in 2005. However, there is no significant trend or change in rate over the past five years. //2009//

/2010/ In 2007, rate of death due to motor vehicle crashes in youths ages 15 to 24 years was 25.0 per 100,000. There has been no significant change with this indicator over the past five years. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	293.2	293.3	256.1	254.7	254.7
Numerator	3147	3148	2763	2768	2768
Denominator	1073202	1073253	1078955	1086602	1086602
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/11/2008.

Narrative:
Since 2002, the rate of all nonfatal injuries among children aged 14 years and younger decreased from 352.1 to 293.2 (there were programming errors in the data run for 2001). Overall, falls, poisoning, and motor vehicle-related injuries account for about 50% of nonfatal injuries for this age group.

/2008/ In 2005, the rate of all nonfatal injuries among children ages 14 years and younger was 282.4 per 100,000 population. The leading causes of these deaths were: unintentional falls, poisoning (both unintentional and self-inflicted), and motor vehicle crashes. //2008//

/2009/ In 2006, the rate of all nonfatal injuries among children ages 14 years and younger was 256.1 per 100,000 population a decrease from 2005. The leading causes of these injuries were: unintentional falls and poisoning (both unintentional and self-inflicted). //2009//

/2010/ In 2007, rate of all nonfatal injuries among children ages 14 years and younger was 254.7 per 100,000 persons. This is consistent with 2006 data. The leading causes of these nonfatal injuries were falls and poisoning. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	29.7	26.0	23.2	21.3	21.3
Numerator	319	276	250	231	231
Denominator	1073202	1062878	1078955	1086602	1086602
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/11/2008.

Narrative:
From 2001-2004, motor vehicle-related crashes accounted for about 10% of nonfatal injuries among children aged 14 years and younger. In 2004, the rate was 29.2, a slight increase from the 2003 rate of 27.3. Overall, the rate has fluctuated since 2001 and there is no discernable trend.

/2008/ The rate per 100,000 population of nonfatal injuries due to motor vehicle crashes among children ages 14 years and younger was 26.0. This does not represent a significant change from the rate in the past five years. //2008//

/2009/ In 2006, the rate per 100,000 population of nonfatal injuries due to motor vehicle crashes among children ages 14 years and younger was 23.2, a slight decrease from 2005. //2009//

/2010/ In 2007, rate per 100,000 population of nonfatal injuries due to motor vehicle crashes among children ages 14 years and younger was 21.3, a slight decrease from 2006. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	149.5	146.7	149.3	149.8	149.8
Numerator	1226	1204	1213	1195	1195
Denominator	819912	820561	812433	797824	797824
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data issue: Data for 2008 will not be available from the Bureau of Health Information andPolicy until 2010.

Notes - 2007
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/10/2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Injury Hospitlization Module, accessed 4/11/2008.

Narrative:
From 2001-2004, motor vehicle-related crashes accounted for 23% of all nonfatal injuries among youth aged 15-24, and 79% of those injuries were occupant motor vehicle traffic crashes. For the period 2001-2004, the 2004 rate was the lowest at 147.0, compared to the highest rate of 207.6 in 2002; there is no discernable trend.

/2008/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth ages 15-24 years was 144.7 in 2005. This is a slight decrease from 2004, and a statistically significant decrease from the rate in 2003. //2008//

/2009/ In 2006, the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth ages 15-24 years was 149.3. This is a slight increase from 2005. //2009//

/2010/ In 2006, rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth ages 15-24 years was 149.3. There was no change in this rate from 2006. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.8	28.0	28.2	28.6	29.9
Numerator	5539	5584	5539	5621	5839
Denominator	199603	199603	196451	196451	195033
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator: Wisconsin Department of Health and Famly Services, Division of Public Health, Wisconsin STD Program, 2009.
Denominator: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2009.

Notes - 2007
Source: Numerator: Wisconsin Department of Health and Famly Services, Division of Public Health, Wisconsin STD Program, 2008.
Denominator: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2008.

Notes - 2006
Source: Numerator: Wisconsin Department of Health and Famly Services, Division of Public Health, Wisconsin STD Program, 2008.
Denominator: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health

(WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2008.

Narrative:
Reported chlamydia morbidity has remained relatively stable among WI women since 2001. The total annual reported morbidity has increased, with greater numbers of men reported in subsequent years. Reported morbidity rates of chlamydia among women over the past 5 years appear to be stable during a time when the volume of screening has steadily increased and significantly more sensitive tests used. This stabilization may be attributable to the impact of the STD Program on reducing morbidity among women through statewide selective screening programs for women at high risk in WI. The rate in 2001 for younger women is almost three times that of older women; in 2004, the rate for women 15-19 was 27.8 compared to a rate of 8.5 for women 20-44.

/2008/ The rates per 1,000 women for 15-19 year olds and 20-44 year olds with a reported case of Chlamydia have steadily increased each year from 2001-2005. A steady increase in the volume of tests performed in women for chlamydia at the WI State Laboratory of Hygiene (WSLH), has also been observed, with 42,085 tests performed in 2001 vs. 50,615 tests performed in 2005. Though not all reported cases had tests performed at the SLH, tests done through the SLH contributed ~ 28% of reported positives among 15-19 year old women and ~ 16% of reported positives among 20-44 year old women. //2008//

/2009/ Reported rates of chlamydia in 15-19 year old and 20-44 year old women continued to increase in 2006 (5,539 and 8,609 per 100,000 respectively) and 2007 (5,621 and 8,703 per 100,000 respectively). In addition, alarming disparities persist by region and race. The 2007 rates of reported chlamydia among African American 15-19 year old girls (12,671 per 100,000) was 13 times the rate reported among white girls (955 per 100,000) living in Wisconsin. In Milwaukee County, 1 of 86 (1,169 per 100,000) white girls age 15-19 were reported with chlamydia in 2007, compared to 1of 105 (955 per 100,000) reported with chlamydia state wide.

In 2006, there were 30,398 reported STD in Wisconsin among all ages, including Chlamydia, gonorrhea, syphilis, and HSV. Chlamydia accounts for 66% of all reported STDs, and 72.1% among ages 15-19. Ages 15-19 accounted for 32% of all reported cases, or a rate of 2,353 per 100,000. The Chlamydia-specific rate per 100,000 ages 15-19 was 1,697 in 2006. After a steady increase from 1997 to 2003, reported cases of Chlamydia have remained steady from 2004 through 2006. Ages 20-44 account for 68% of reported STDs, and ages 20-29 account for 58% of reported STDs. The rate per 100,000 in 2006 (for the above STDs) was 2,551 for ages 20-24, 1,376 for ages 25-29, and 597 for ages 30-34.

Source: Wisconsin STD Surveillance Data Cases diagnosed in 2006. //2009//

/2010/ See #05B. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.5	9.1	7.4	7.4	9.6
Numerator	8215	8799	8703	8609	8991
Denominator	962803	962803	1169835	1169835	933425
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator: Wisconsin Department of Health Services, Division of Public Health, Wisconsin STD Program, 2009.
Denominator: Source: Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2009.

Notes - 2007
Source: Numerator: Wisconsin Department of Health and Famly Services, Division of Public Health, Wisconsin STD Program, 2008.
Denominator: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2008.

Notes - 2006
Source: Numerator: Wisconsin Department of Health and Famly Services, Division of Public Health, Wisconsin STD Program, 2008.
Denominator: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query sytem, http://dhfs.wisconsin.gov/wish/, Population Module, accessed 02/4/2008.

Narrative:
See #05A

/2008/ See #05A. //2008//

/2009/ See #05A. //2009//

/2010/ Reported chlamydia morbidity has remained relatively stable among WI women since 2003, with slight increases from 2003-2005. The total annual reported morbidity has increased, with greater numbers of men reported during this time period than previously.

Reported case rates of chlamydia per 1000 women 15-19 years old remained relatively stable from 2004-2007 (~28.0) with a slight increase in 2008 to 29.9. Among women 20-44 years of age, rates began to decline in 2006-2007 to 7.4 from 9.1 in 2005; however the rate in 2008 was back up to 9.6. Reported morbidity rates of chlamydia among women over the past 5 years appear to be stable while the volume of screening steadily increased through 2007 at the WI State Laboratory of Hygiene (SLH). The volume of 2008 SLH Chlamydia tests decreased for the first time in the last 5 years to 68,590 total tests among women and men, compared to 68,839 total tests in 2007. Contributing to this decrease in test volume may be standard of care changes in the frequency of pelvic exams required for PAP testing and contraceptive visits for family planning women, which allows for delayed pelvic exams. Increased emphasis on urine-based specimens from women may bring this volume back up in 2009-10.

Relatively stable reported case rates observed during this time period may be attributable to the statewide selective screening programs for family planning women at high risk in

WI. Women attending family planning clinics must meet at least one of the evidence based risk factors included in the WI Selective Screening Criteria (SSC) to qualify for 'no charge' testing for chlamydia. In some higher morbidity areas of the state, age-based screening (with no other risk factors) occurs. However, SSC data continue to support the requirement of other risk factor criteria in order to qualify for a 'no charge' test, as the age group with the highest risk rate continues to be the 15-19 year old age group, with a rate in 2008 of 29.9 per 1000 women 15-19, which is more than 3 times the rate of 9.6 per 1000 women 20-44 years of age. The SSC in use since 1985 for family planning women were established through evidence based prevalence evaluations. These criteria have been re-evaluated and modified over time through subsequent studies. The current SSC prove to be sensitive and cost effective predictors of infection in the family planning population of women. A sixth re-evaluation of SSC is currently underway.

Alarming disparities in prevalence continue to persist by region and race. The 2007 rates of reported chlamydia among African American 15-19 year old girls in Milwaukee County (137 per 1000) was 13 times the rate reported among white girls in Milwaukee County (12 per 1000). In Milwaukee County, 1 of 86 (12 per 1000) white girls age 15-19 were reported with chlamydia in 2007, compared to 1of 105 (10 per 1000) reported with chlamydia state wide. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	72626	61015	6876	868	1834	37	1996	0
Children 1 through 4	286202	240218	25569	3792	8511	128	7984	0
Children 5 through 9	356005	300209	30969	4229	10469	175	9954	0
Children 10 through 14	371768	314808	32522	4332	11170	174	8762	0
Children 15 through 19	402173	345638	34051	5155	10407	199	6723	0
Children 20 through 24	395652	348206	28200	4676	9205	200	5165	0
Children 0 through 24	1884426	1610094	158187	23052	51596	913	40584	0

Notes - 2010

Narrative:
Of the 1,882,887 Wisconsin residents under 25 years of age, 85.6% are white, 8.4% are African American, 6.3% are Hispanic/Latino, 1.2% is American Indian, 2.7% are Asian, and 1.9% are multiracial. The fastest growing ethnic group in Wisconsin is Hispanic/Latino. Although 6.3% of the total population under 25 is Hispanic/Latino, 8.4% of babies less than one year of age are in this group.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	65784	6842	0
Children 1 through 4	260597	25606	0
Children 5 through 9	327314	28691	0
Children 10 through 14	346381	25387	0
Children 15 through 19	380133	22039	0
Children 20 through 24	372691	22061	0
Children 0 through 24	1752900	130626	0

Notes - 2010

Narrative:
Of the 1,882,887 Wisconsin residents under 25 years of age, 85.6% are white, 8.4% are African American, 6.3% are Hispanic/Latino, 1.2% is American Indian, 2.7% are Asian, and 1.9% are multiracial. The fastest growing ethnic group in Wisconsin is Hispanic/Latino. Although 6.3% of the total population under 25 is Hispanic/Latino, 8.4% of babies less than one year of age are in this group.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	80	32	38	6	4	0	0	0
Women 15 through 17	1874	1126	577	85	72	14	0	0
Women 18 through 19	4366	2984	1021	176	154	26	0	5
Women 20 through 34	56795	48443	5186	917	1500	715	0	34
Women 35 or older	9630	8650	481	79	312	97	0	11
Women of all	72745	61235	7303	1263	2042	852	0	50

ages								

Notes - 2010
There were 12 infants born to women of unknown age: White - 3, Other & Unknown - 9; therefore, the total is 72,757 live births.

Narrative:
In Wisconsin, 70,131 infants were born to women in 2004. Of that total, 8.7% were born to women under 20 years of age, 77.5% were born to women 20 to 34 years of age, and 13.8% were born to women 35 and older. Teen pregnancy continues to be a problem in the African American community. 23.3% of African American babies were born to mothers under 20 while only 6.8% of white babies were born to mothers in this age group. 14.7% of white babies were born to mothers 35 and older while only 6.5% of African American babies were born to mothers in this age group. 5,915 babies were born to Hispanic/Latino women in Wisconsin in 2004. 15.5% of Hispanic/Latino babies were born to mothers under 20 years of age, 76.6% were born to mothers 20 to 34 years of age, and 7.9% were born to mothers 35 and older. From 1994-2005, the past decade, the proportion of Wisconsin births to non-Hispanic white women decreased from 83% to 77%, reflecting our increasing population diversity, primarily due to Hispanic/Latino immigration.

/2008/ No significant change. //2008//

/2009/ There were 72,302 births that occurred to Wisconsin residents in 2006. (Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Births and Infant Deaths, 2006 (PPH 5364-06). September 2007). Overall, 75.4% of births where to white mothers, followed by 9.7% to African American mothers, 1.6% to American Indian mothers, 9.4% to Hispanic/Latino mothers, 1.7% to Laotian/Hmong mothers, and 2.0% to Other Asian mothers. 8.4% were born to women under 20 years of age, 77.8% were born to women 20 to 34 years of age, and 13.7% were born to women 35 and older. Teen births (to women <20 years of age) represented 8.4% of births overall. However, by race/ethnicity, African American teens have the highest percentage of births at 29.9%, followed by Laotian/Hmong at 16.5%, American Indian at 15.8%, Hispanic/Latino at 14.2%, and White at 5.6%. Wisconsin's race/ethnicity-specific birth rates have decreased since 1990 for non-Hispanic whites, African American, and Asians; the American Indian birth rate has gradually increased since 1990 from 85.7 per 1,000 to 95.2 in 2006, and the Hispanic/Latino birth rate increased from 85.1 in 1990 to 111.8 in 2006. //2009//

/2010/ See #07B. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	61	19	0
Women 15 through 17	1484	390	0
Women 18 through 19	3691	674	1
Women 20 through 34	51611	5182	2

Women 35 or older	8984	646	0
Women of all ages	65831	6911	3

Notes - 2010

Narrative:
See #07A.

/2008/ No significant change. //2008//

/2009/ See #07A. //2009//

/2010/ There were 72,757 live births that occurred to Wisconsin residents in 2007. (Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Births and Infant Deaths, 2007 (P-45364-07). November 2009). Overall, 74.9% of births were to non-Hispanic white mothers, followed by 9.9% to non-Hispanic African American mothers, 1.6% to American Indian mothers, 9.5% to Hispanic/Latino mothers, 1.8% to Laotian or Hmong mothers and 2.2% to mothers in other Asian groups (Chinese, Japanese, and Korean). 8.7% were born to women under 20 years of age, 78.1% to women 20 to 34 years of age, and 13.2% to women 35 and older. By race ethnicity, African American teens had the highest percentage of births at 22.3%, followed by American Indian at 20.2%, Laotian or Hmong at 16.8%, and Hispanic/Latino at 15.7%. Compared to 1997, non-Hispanic whites had the largest decrease in percentage of births from 81.6% then to 74.9% in 2007, the proportion of African American, American Indian, and Laotian or Hmong births increased slightly from 9.6% to 9.9%, 1.2% to 1.6%, and 1.6% to 1.8% respectively. Hispanics/Latinos had the largest percentage increase from 1997 to 2007, from 4.8% to 9.9%. Wisconsin's overall percent of births to unmarried mothers in 2007 was 36.8%, lower than the national rate of 39.7% in 2007. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	423	280	112	12	12	5	2	0
Children 1 through 4	66	45	17	2	1	1	0	0
Children 5 through 9	48	40	6	0	1	1	0	0
Children 10 through 14	57	54	2	0	1	0	0	0
Children 15 through 19	239	186	42	6	3	2	0	0
Children 20 through 24	333	269	43	6	11	3	0	1
Children 0 through 24	1166	874	222	26	29	12	2	1

Notes - 2010

Narrative:
1,158 Wisconsin children died in 2004. 36.2% were under one year of age, 5.7% were 1 to 4, 4.0% were 5 to 9, 5.7% were 10 to 14, 19.8% were 15 to 19, and 28.4% were 20 to 24. Infant mortality is much higher for African Americans than for whites. Of the 219 deaths among African Americans under 25 in 2004, 58.4% (128) were babies under one year of age, a rate of 19.42 per thousand. By comparison, of the 877 deaths among whites under 25 in 2004, 31.0% (272) were babies under one year of age, a rate of 4.53 per thousand. 67 Hispanic children died in Wisconsin in 2004. More than 50% (35) were babies under one year of age, a rate of 5.92 per thousand.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2008/ No significant change. //2008//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	375	48	0
Children 1 through 4	59	7	0
Children 5 through 9	43	5	0
Children 10 through 14	54	3	0
Children 15 through 19	224	15	0
Children 20 through 24	306	27	0
Children 0 through 24	1061	105	0

Notes - 2010

Narrative:
1,158 Wisconsin children died in 2004. 36.2% were under one year of age, 5.7% were 1 to 4, 4.0% were 5 to 9, 5.7% were 10 to 14, 19.8% were 15 to 19, and 28.4% were 20 to 24. Infant mortality is much higher for African Americans than for whites. Of the 219 deaths among African Americans under 25 in 2004, 58.4% (128) were babies under one year of age, a rate of 19.42 per thousand. By comparison, of the 877 deaths among whites under 25 in 2004, 31.0% (272) were babies under one year of age, a rate of 4.53 per thousand. 67 Hispanic children died in Wisconsin in 2004. More than 50% (35) were babies under one year of age, a rate of 5.92 per thousand.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ No significant change. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1488774	1261889	129986	18375	42391	714	35419	0	2007
Percent in household headed by single parent	13.9	25.3	52.8	2.1	2.9	0.0	22.3	0.0	2007
Percent in TANF (Grant) families	3.1	25.3	52.8	2.1	2.9	0.0	1.2	7.2	2004
Number enrolled in Medicaid	403947	202886	87414	9870	16104	564	7796	79313	2008
Number enrolled in SCHIP	42495	31376	5738	824	1699	72	720	2066	2008
Number living in foster home care	7396	3905	2927	306	85	0	0	173	2008
Number enrolled in food stamp program	333785	148270	90399	7707	12387	1015	8118	65889	2008
Number enrolled in WIC	107974	65053	26765	2494	6009	153	7500	0	2008
Rate (per 100,000) of juvenile crime arrests	7460.6	6246.6	20499.3	16711.4	5685.7	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	2.1	1.3	7.2	5.0	1.9	0.0	0.0	0.0	2007

Notes - 2010

Source: Wisconsin Dept. of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/. Population Module, accessed 04/01/09.

Source: American Community Survey, 2007. "More than one race" is Some Other Race, Nat Haw/Other Pac Islander is Not Available. Other/Unknown is Not Available.

Source: Most recent data available. FY 2003. Source: National TANF Datafile as of 03/04/2004. TANF Seventh Annual Report to Congress.

Source: Medicaid Evaluation and Decision Support Data Warehouse for SYF 2008.

Source: Medicaid Evaluation and Decision Support Data Warehouse for SFY 2008.

Source: Wisconsin Department of Children and Families, 2009.

Source: Wisconsin WIC Program's Real-Time Online Statewide Information Environment (ROSIE) for CY 2008. WIC data are for children, ages 0 - 4; these data include Hispanic ethnicity as a race and not as an ethnic classification.

Source: Most recent data available. Statistical Analysis Center, Wisconsin Crime and Arrests, Wisconsin Department of Justice Assistance, 2007. Uniform Crime Reporting Program.

Source: Wisconsin Department of Public Instruction. 2007-2008 School Year.

Source: Wisconsin Department of Children and Families, 2009.

Narrative:
There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state agencies, they are not defined consistently (numbers, rates, percentages), and methodologies for their collection and reporting change from year to year and by agency. About 27% of Wisconsin's population is children, ages 0-19. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile crime arrest, and enrollment numbers for Medicaid/BadgerCare have been increasing. However, when examined by race/ethnicity, there are outstanding disparities; for example, there are almost as many black children in foster care home as white children, even though black children comprise 9% of the children 0-19, while white children account for 85%. Other examples are the rates of juvenile violent crime arrest and percentage of high-school drop outs: children of color have higher rates than whites. Section III - State Overview, of the 2007 MCH Title V Block Grant Application, describes other significant disparities for Wisconsin's children.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ Although there are no significant changes in these data indicators that describe the demographics of Wisconsin's children, most of these indicators have slight increases from the previous years. Most likely, these increases are a reflection of the economic crisis that Wisconsin is facing as women, children, and families are affected by job losses, and the impacts of those losses as they trickle down through every day living patterns and habits. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1380209	108565	0	2007
Percent in household headed by single parent	0.0	8.5	0.0	2007
Percent in TANF (Grant) families	0.0	8.5	0.0	2004
Number enrolled in Medicaid	403947	56075	0	2008
Number enrolled in SCHIP	42495	5705	0	2008

Number living in foster home care	6786	610	1498	2008
Number enrolled in food stamp program	256585	44569	37031	2008
Number enrolled in WIC	72819	35155	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	5.0	0.0	2007

Notes - 2010
Source: Wisconsin Dept. of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish/. Population Module, accessed 04/01/09.

Source: American Community Survey, 2007.

Source: Most recent data available. FY 2003. Source: National TANF Datafile as of 03/04/2004. TANF Seventh Annual Report to Congress.

Source: Medicaid Evaluation and Decision Support Data Warehouse for SFY 2008.

Source: Medicaid Evaluation and Decision Support Data Warehouse for SFY 2008.

Source: Wisconsin Department of Children and Families, 2009.

Source: Wisconsin WIC Program's Real-Time Online Statewide Information Environment (ROSIE) for CY 2008. WIC data are for children, ages 0 - 4; these data include Hispanic ethnicity as a race and not as an ethnic classification.

Source: Most recent data available. Ethnicity data are not available.
Statistical Analysis Center, Wisconsin Crime and Arrests, Wisconsin Department of Justice Assistance, 2007. Uniform Crime Reporting Program.

Data issue: Hispanice may be any race.
Source: Wisconsin Department of Public Instruction. 2007-2008 School Year.

Source: Wisconsin Department of Children and Families, 2009.

Narrative:
There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state agencies, they are not defined consistently (numbers, rates, percentages), and methodologies for their collection and reporting change from year to year and by agency. About 27% of Wisconsin's population is children, ages 0-19. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile crime arrest, and enrollment numbers for Medicaid/BadgerCare have been increasing. However, when examined by race/ethnicity, there are outstanding disparities; for example, there are almost as many black children in foster care home as white children, even though black children comprise 9% of the children 0-19, while white children account for 85%. Other examples are the rates of juvenile violent crime arrest and percentage of high-school drop outs: children of color have higher rates than whites. Section III - State Overview, of the 2007 MCH Title V Block Grant Application, describes other significant disparities for Wisconsin's children.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ Although there are no significant changes in these data indicators that describe the demographics of Wisconsin's children, most of these indicators have slight increases from the previous years. Most likely, these increases are a reflection of the economic crisis that Wisconsin is facing as women, children, and families are affected by job losses, and the impacts of those losses as they trickle down through every day living patterns and habits. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1143775
Living in urban areas	1099598
Living in rural areas	389176
Living in frontier areas	0
Total - all children 0 through 19	1488774

Notes - 2010

Narrative:
In 2004, 1,482,334 children under the age of 20 lived in Wisconsin. 15.4% lived in rural areas and 84.6% lived in urban areas.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ In 2007, 1,488,774 children under the age of 20 lived in Wisconsin. 26.1% lived in rural areas and 73.8% lived in urban areas. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5641581.0
Percent Below: 50% of poverty	4.0
100% of poverty	11.4
200% of poverty	26.7

Notes - 2010

Narrative:
Approximately 5.5 million people lived in Wisconsin in 2004. Four percent (about 220,000) subsisted at less than 50% of the federal poverty level, 9% (about half a million) at 100% FPL, and 24% (about 1.3 million) at 200% FPL.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ In 2007, approximately 5.6 million people lived in Wisconsin. Four percent (224,000) subsisted at less than 50% of the federal poverty level, 11.4% (638,400 at 100% FPL, and 26.7% (about 1.5 million) at 200% FPL.) //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1488774.0
Percent Below: 50% of poverty	5.6
100% of poverty	16.7
200% of poverty	31.8

Notes - 2010

Narrative:
Approximately 1.5 million children under 20 lived in Wisconsin in 2004. Five percent (about 75,000) subsisted at less than 50% of the federal poverty level, 12% (about 180,000) at 100% FPL, and 28% (about 420,000) at 200% FPL.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

/2010/ The proportion of children living in poverty in Wisconsin has increased. Of the 1.5 million children under 20 in Wisconsin, in 2007, about 83,000 (5.6%) subsisted at less than 50% of the federal poverty level, 16.7% (about 250,000) at 100% of the federal poverty level, and almost one-third (31.8%, about 470,000) at 200% federal poverty level. //2010//

F. Other Program Activities

Public Health Information and Referral (PHIR) Services for Women, Children and Families (hotline services) - Gundersen Lutheran Medical Center - LaCrosse -- Since 1995, the MCH Hotline has provided comprehensive information on the various MCH programs in Wisconsin. During this time, the need has grown for other state health-focused programs to establish a toll-free hotline and supporting information and referral service. In order to avoid unnecessary duplication, the state combined the needs of these programs into one comprehensive PHIR service for women, children and families provided by one agency, Gundersen Lutheran Medical Center, La Crosse, Wisconsin. The purpose of developing a comprehensive hotline system is to streamline the mechanism by which individuals and families can receive information and access specific providers in Wisconsin. This agency combines information and referral services for the following programs:

- MCH Hotline, including the CYSHCN Program and reproductive health (800) 722-2295
- Services Hotline for Women, Children and Families (ACT 309) (877) 855-7296
- Supplemental Nutrition Program for Women, Infants and Children (WIC) (800) 722-2295
- Wisconsin Medicaid, including HealthCheck and Healthy Start (800) 722-2295
- Wisconsin Birth to 3 Program & Regional CYSHCN Centers (First Step Hotline) (800) 642-7837

In 2004 the MCH Hotline received 8,549 calls; an increase of 516 calls from 2003. The website address is www.mch-hotlines.org.

In 2004, the First Step Hotline received 2,103 calls in 2004; an increase of 604 calls from 2003. In addition, the CYSHCN Program maintains a toll-free phone number (800) 441-4576 to assist parents and providers regarding children with special health care needs.

The Statewide Poison Control System was implemented on July 1, 1994, with state GPR funds ($375,000) and a 50% match requirement from each regional poison control center. The program provides Wisconsin citizens with the following services: a toll-free hotline allowing easy access for poison control information; quality interpretation of poison information and needed intervention; and education materials for consumers and professionals. As of July 1, 2001 the Wisconsin Poison System contract solely supports the poison control center located at the Children's Hospital of Wisconsin (CHW), Milwaukee. The University of Wisconsin Hospital and Clinics, Madison continues to support the poison control system in Wisconsin by staffing a Poison Prevention Education Center. The Children's Hospital of Wisconsin Poison Center received 64,836 total calls during CY 2004; 43,718 were human exposure calls. In February 2005 this center received full certification by the American Association of Poison Control Centers (AAPCC). This new certification makes the Poison Center the first in Wisconsin history to become nationally certified.

/2007/ The MCH Hotline received 9,025 calls in 2005; an increase of 476 calls from 2004. The Wisconsin First Step Hotline received 2,185 calls in 2005; an increase of 82 calls from 2004. The Children's Hospital of Wisconsin Poison Center received 76,997 total calls in CY 2005; nearly 60% of the calls were regarding a poison exposure. //2007//

/2008/ The MCH Hotline received 11,196 calls in 2006; an increase of 2,171 calls from 2005. The Wisconsin First Step Hotline received 2,344 calls in 2006; an increase of 159 calls from 2005. The Wisconsin Poison Center received 60,764 total calls in CY 2006; nearly 70% of the calls were regarding a poison exposure. //2008//

/2009/ The MCH Hotline received 8,634 calls in 2007; a decrease of 2,562 calls from 2006. The Wisconsin First Step Hotline received 1,932 calls in 2007; a decrease of 412 calls from 2006. The Wisconsin Poison Center received 52,834 total calls in CY 2007; nearly 85% of the calls were regarding a poison exposure.

This decrease is due to the Hotline not needing to take calls for the BadgerCare program in 2007. (In 2006, there were 1,669 calls related to BadgerCare.) Also, calls made to an agency on behalf of a caller are currently logged as 1 call whereas previously they were recorded as 2 calls, from the caller and to the agency.

The Wisconsin Birth Defects Prevention and Surveillance Program released a new report, "Wisconsin Birth Defects Registry 2007 Annual Report", (PPH 40150). The report can be downloaded, viewed, and printed from the website at http://dhfs.wisconsin.gov/DPH_BFCH/cshcn/bdpsdesc/bdpssystem.htm. The program focuses on prevention and access to services through 3 projects. The 'Women's Health Now and Beyond Pregnancy" project is a preconception program promoting the use of multi-vitamins with 400 mcg of folic acid and providing the multi-vitamin to women after delivery. Another project is the "Wisconsin Stillbirth Services Program" at the University of Wisconsin's Clinical Genetics Center to help investigate the causes of stillbirths (http://www.wisc.edu/wissp/).

The third project funded by the Wisconsin Birth Defects Prevention and Surveillance Program is the "Nourishing Special Needs Infants and Children: Wisconsin WIC Partnership." This pilot project, currently at 8 WIC sites though-out Wisconsin, is a collaborative effort between WIC Nutritionists, DPH Regional Office, State WIC and CYSHCN programs, and the UW-Pediatric

Pulmonary Center. The project builds on the existing capacity of the WIC program to improve access to nutrition services and support for infants and children with birth defects and other special health care needs. Program goals are to: identify nutrition-related concerns early, provide access to formula and medical nutrition products, make referral to other programs, provides care giver education and support, screen for the need for medical nutritional therapy, and assist families by communicating with providers. //2009//

/2010/ MCH Hotline received 8,477 calls in 2008; a decrease of 166 calls. The WI First Step Hotline received 1,792 calls in 2008; a decrease of 140 calls. Website "hits" continue to increase, documenting that people are also using the internet to receive their information. This explains the decrease in calls on both lines. The WI Poison Center received 51,530 total calls in CY 2008; over 86% of the calls were regarding a poison exposure.

The WI Birth Defects Prevention and Surveillance Program now supports 9 WIC sites through the Integrative Model for Nutrition Services Capacity Building through Local WIC Programs - Birth Defects Nutrition Consultant Network. This program demonstrates that WIC agencies have improved their ability to identify children with birth defects and other health care needs, their communication and collaboration with local agencies serving young children (i.e. Birth-3, CYSHCN Regional Centers); and their care and interventions for children with birth defects and other health conditions.

The CYSHCN Program has been awarded a 3 year federal grant as part of the Combating Autism Act Initiative, to strengthen the state's infrastructure to improve services for children with ASD and other developmental disabilities. The CYSHCN Program was awarded this grant based on the fact its mission is to promote family-centered, community-based, culturally-competent, coordinated care for all children and youth with special needs. The Waisman Center's University Center for Excellence in Developmental Disabilities is a key collaborator with project staff, an integrated management team and a role in promoting collaboration between several Waisman and CYSHCN Program early identification initiatives.

WI was 1 of 6 states awarded the Kellogg Action Learning Collaborative "Partnership to Eliminate Disparities in Infant Outcome" with an emphasis on racism and the impact on birth outcomes. WI's focus is on 1 key issue in the link between racism and infant mortality: the role of men and fathers. The action plan has identified 3 strategies: education forum on understanding and un-doing racism, a media campaign featuring positive father images, and a pilot project on empowerment coaching for men. These strategies will be kicked off at the Milwaukee Fatherhood conference October 2009.

WI was awarded PRAMS in 2006; it is a collaborative project between BHIP and MCH. The data from PRAMS are not available in other sources and will complement the Department's Healthy Birth Outcomes Initiative. 2009 is the 3rd year of data collection; overall response rates for 2007 and 2008 are 57% and 54% respectively. By stratum, response rates are: 2007- African American - 39%, White - 80%, other - 54%; 2008 - African American - 35%; White - 71%, other - 56%. The PRAMS data for 2007 will be analyzed and preliminary results will be presented in October 2009. //2010//

G. Technical Assistance

Wisconsin requests technical assistance for our adolescent health program. We are requesting assistance from AMCHP to facilitate collaboration with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health.

Wisconsin requests technical assistance on MCHB's expectation of how the work and activities of the ECCS Program need to be integrated into the ongoing MCH/CSHCN Programs, with particular attention needed in the areas of Mental Health and Social-Emotional Development,

Parenting Education, and Family Support.

Wisconsin requests technical assistance in designing and writing specifications for an on-line child health profile to be integrated into the existing WI Pubic Health Integrated Network (PHIN) and the Secure Public Health Electronic Record Environment (SPHERE). The child health profile would be used by primary care providers and the public health community.

Wisconsin requests technical assistance and information related to eliminating racial and ethnic disparities in birth outcomes. This could include on site-visits, expert consultation, and information from other states and cities (similar in demographics to Milwaukee, WI) who have implemented best practices and effective methods.

/2007/ No significant change. //2007//

/2008/ Wisconsin requests technical assistance to check in with other states to see what they are doing with their MCH Advisory Committees.

Wisconsin requests technical assistance to see how other states are capturing their MCH services supported by their MCH dollars, vs. capturing all their MCH related services that are not covered by their MCH dollars but are likely to be offered because of the MCH support/infrastructure/programming.

Wisconsin requests technical assistance in identifying and reviewing core competencies of its MCH staff. How can we assure that we are addressing the MCH program needs at the local, state, and federal levels with declining and/or changing staffing patterns.

Wisconsin requests technical assistance in exploring what other states have done as far as the design, development and promotion of a child health profile that could be used by primary care providers and the public health community. //2008//

/2009/ Wisconsin requests technical assistance in preparing and planning for our next five year needs assessment. We are looking for guidance and ideas for conducting our needs assessment, integrating our 2020 State Health Plan planning efforts and our priorities from our present needs assessment and the future needs assessment efforts.

Wisconsin requests technical assistance in identifying what other state MCH programs are using as their data collection tool/system for reporting their grant required data and performance measures. Is there off the shelf software states are using or have states developed their own systems? Can they share their systems with other states? //2009//

/2010/ Wisconsin will look into requesting technical assistance in moving forward with the upgrading of the SPHERE platform. A Request for Information (RFI) is planned to be developed in the upcoming year, exploring vendors who may be able to assist the MCH Programs in moving forward with next steps in upgrading SPHERE based on recommendations made by a statewide workgroup facilitated by the Bureau of Information Technology within the Department in 2008. //2010//

V. Budget Narrative

A. Expenditures

Significant Variances - Forms 3, 4, and 5 -- 2008 Budgeted/Expended

Form 3

Program Income
This variance, an increase of $3,021,270 (67.3%), is the result of increased income earned by family planning agencies. This increase is due primarily to the substantial increase in the cost of family planning supplies, which is passed on by local provider agencies to clients via sliding fee scales. This exceptionally large increase has led to additional variances for the Children and Other Type of Individuals Served categories on Form 4 and the Direct Type of Services category on Form 5.

Form 4

Pregnant
This variance, a decrease of $864,259 (30.04%), is due to a general decrease in the number of clients in this category served with Title V dollars. This subsequently affects other components of the Federal/State Partnership. Title V funds decreased by $208,285, Match funds by $335,267 and Program Income fund by $320,707.

Children
This variance, an increase of $1,390,773 (15.73%), is due primarily to a significant increase in Program Income in this category of $1,527,698. This was off set slightly by minor decreases in Title V spending and Match dollars in this category.

Other
This variance, an increase of $2,067,974 (50.96%), is due almost exclusively to an increase in Program Income of $1,786,906. An increase in Match funds also contributed to the variance.

Administration
This variance, an increase of $89,964 (14.74%), is due to an error in the 2008 Budgeted calculation. The cost of one position allocated to Administration was inadvertently omitted from the total. When this cost of $49,546 is included, the total Budgeted Administration cost increases to $659,989. The variance then becomes $40,418, or only 6.1%.

Form 5

Direct
This variance, an increase of $3,022,807 (24.03%), is due primarily to an increase of $2,719,143 in Program Income. Increased Maintenance of Effort funds also contributed.

B. Budget

The Title V MCH/CYSHCN Program award of $10,824,984 is budgeted into two broad categories, State Operations and Local Aids. Please see the attached file for full details.

See Attachment to Section V. B. - Budget (Title V MCH/CYSHCN Program Budget)
An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.